

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 8

1. PLACE OF DEATH:

County... Allegany
 City or town... Lord - near Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 27 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Allegany
 City or town... Lord - near Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No...
 (If rural, give LOCATION)
 2(a) If veteran, name war... none

3. (a) FULL NAME

Mrs. Jennie Gardner (Allen)

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife George Allen7. Birth date of deceased (mo., day, yr.) Sept 24 1893 6. (c) If alive, give age 56 years8. AGE: Years 53 Months 8 Days - If less than one day hrs. min.9. Birthplace Lonaconing, Allegany Co., Md.
(Town, county, and state)10. Usual occupation Housework11. Industry or business Own home12. Name William A. Gardner13. Birthplace Lonaconing, Md.14. Maiden name Sarah Jane Wilson15. Birthplace Lonaconing, Allegany Co., Md.16. Informant Wm. S. G. GaltAddress Lonaconing, Md.17. Burial Date thereof April 27, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oak Hill CemeteryLocation Lonaconing, Md.18. Funeral director M. BuchhornAddress Lonaconing, Md.19. 4/26 19 47 Jannette M. Boal
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24th 19 47 at 10:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 24 19 47 to Apr 24 19 47 and that I last saw him alive on Apr 24 19 47Immediate cause of death Sepsis due to an infected leg.Due to...
Due to...
Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations... Date of op...

Autopsy results...
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?23. SIGNATURE Harry D. Hodgeson Jr. M. D. or other
Address Lonaconing, Md. Date signed Apr 26 47

RECEIVED
APR 29 1947
BUREAU 78

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-1

00531

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 23 yrs.
 Hospital, institution, or street address where death occurred:
3 Fayette St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3 Fayette St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Juanita Maye Allen.

3. (b) Social Security Number

None

4. Sex 5. Color of face 6. (a) Single married, widowed, or divorced

Female Colored Single

6. (b) Name of husband or wife

6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) April 14 1924

8. AGE: Years 23 Months — Days 16 If less than one day hrs. min.

9. Birthplace Cumberland Ind.
 (Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Saylor Allen
 13. Birthplace va.

14. Maiden name Dora Brassiey
 15. Birthplace Cumberland Ind.

16. Informant Mrs Dora Allen
 Address Cumberland Ind.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof May 8 47
 (month) (day) (year)

Cemetery or crematory Summer Cem.
 Location Cumberland

18. Funeral director Louis Stein Inc
 Address Cumberland

19. May 2 19 47 J.P. Traublin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 19 47 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-7-47 19 47 to 4-30-47 19 47
 and that I last saw her alive on 4-28-47 19 47

Immediate cause of death Pulmonary Tuberculosis

Due to Pulmonary Tuberculosis
 Due to —

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.F. Williams

M. D. or other —
 Address Cumberland Date signed 5-1-47

MARGIN RESERVED FOR BINDING

VS A15 9-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 3 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1572

00532

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... ALLEGANY
 City or town... CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
 How long in hospital or institution?..... 5 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... GARRETT
 City or town... OAKLAND
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... ROUTE # 1
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

MISS DONNA LOUISE BAKER

3. (b) Social Security Number

None

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced SINGLE
 6. (b) Name of husband or wife.....
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) NOVEMBER 19, 1946
 8. AGE: Years Months Days If less than one day
4 28 hrs. min.

9. Birthplace... MARYLAND
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name JOHN E. BAKER13. Birthplace WEST VIRGINIA14. Maiden name MCROBIE, DOROTHY E.15. Birthplace MARYLAND16. Informant MEMORIAL HOSPITALAddress CUMBERLAND, MARYLAND

17. Burial Date thereof April 19, 1947
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Oakland CemLocation Oakland, Md.18. Funeral director Amroy BoldenAddress Oakland, Md.

19. April 17, 1947 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17, 1947 at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 17, 1947 to April 17, 1947
 and that I last saw him alive on April 17, 1947

Immediate cause of death.....

DURATION

Congenital Endocarditis 5 mos

Due to.....

Due to.....

Other conditions Disruptive Hemorrhage 2 wks

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE C. L. Owens M.D.

M. D. or other

Address Cumberland Md Date signed 4-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 22 1947

BUREAU V 8

Within 10 days after death

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107

00533

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 Mo 11 Days
Hospital, institution, or street address where death occurred:
331 Central Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 331 Central Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Don Cedric Beard

3. (b) Social Security Number

None

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife
B. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 10 1946

8. AGE: Years 6 Months 11 Days 11 If less than one day hrs. min.

9. Birthplace Cumberland, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name Leonard Beard
13. Birthplace Cumberland, Md.
14. Maiden name Therssa Denmark
15. Birthplace Cumberland, Md.

16. Informant Leonard Beard
Address 331 Central Ave, Cumberland, Md.

17. Burial Date thereof 4/23/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Sumner Cemetery
Location Cumberland, Md.

18. Funeral director William H. Kight
Address Cumberland, Md.

19. April 25, 1947 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1947, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 21 1947 to April 21 1947 and that I last saw him alive on April 21 1947

Immediate cause of death Pneumonia DURATION 1 week

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. M. Schindler, M.D. M. D. or other

Address 41 Greene St, Cumberland, Md Date signed April 23, 1947

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 29 1947

BUREAU 7 A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15

00534

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegheny
 City or town Greensburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 hours
 Hospital, institution, or street address where death occurred:
Allegheny Hospital
 How long in hospital or institution? 3 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Garrett
 City or town Greensburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Richard Dale Beitzell

3. (b) Social Security Number

none

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 10 1947
 6. (c) If alive, give age _____ years

8. AGE:

Years _____ Months 0 Days 16 If less than one day _____ hrs. _____ min.

9. Birthplace

Greensburg Garrett Co. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

Clayton E. Beitzell

12. Name

Bittinger, 2nd

13. Birthplace

Betty Dixon

14. Maiden name

accident and

15. Birthplace

William Winterberg

16. Informant

Greensburg Md

Address

Bureau

17. (Burial, cremation, or removal. Which?) Date thereof 4/27/47
 (month) (day) (year)

Cemetery or crematory

Blooming Rose Cem

Location

Friendsville Md

18. Funeral director

William Winterberg

Address

Greensburg Md

19. April 27, 47 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1947, at 7 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 26 1947 to April 26 1947
 and that I last saw him alive on April 26 1947
 Immediate cause of death Brain Les. Pneumonia DURATION _____
 Due to Malnutrition
 Due to _____
 Other conditions _____
 (Include pregnancy within 8 months of death)
 Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE J. K. Curran, Jr. M. D. or other _____
 Address Greensburg Md Date signed 4/27/47

MARGIN RESERVED FOR BINDING

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9-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 3 1947
BUREAU F B I

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00535

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 Months
Hospital, institution, or street address where death occurred:
Bedford Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Ohio County Columbiana
City or town Lisbon
(If outside city or town limits, write RURAL and give nearest town)
Street No. Pleasant Heights
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

John H. Brayley

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife A da Jones Brayley

6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) April 19 1875

8. AGE: Years 71 Months 11 Days 12 If less than one day hrs. min.

9. Birthplace Wales England
(Town, county, and state)

10. Usual occupation Coal Miner

11. Industry or business Digging Coal

12. Name Thomas Brayley

13. Birthplace Wales England

14. Maiden name Mary (Unknown)

15. Birthplace Wales England

16. Informant Mrs. Carl C. Robbins

Address City Rt 23, Cumberland, Md.

17. Burial Burial Date thereof 4/4/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lisbon Cemetery

Location Lisbon, Ohio

18. Funeral director William H. Kight

Address Cumberland, Md.

19. April 2 19 47 J. P. Frankh, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/1/47 19 47 at 6 p M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1/47 19 47 to 4/1/47 19 47 and that I last saw him alive on 4/1/47 19 47

Immediate cause of death Myocardial Failure

Due to Bronchial Asthma

Due to Supraventricular of age

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

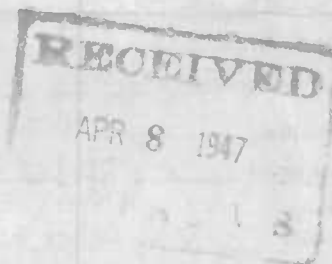
23. SIGNATURE R. J. Williams, M.D. M. D. or other

Address West Blvd, Cumberland, Md. Date signed 4/4/47

MARGIN RESERVED FOR BINDING

VS A15 9-4-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County allegany
City or town Smithsburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
36 Stoper St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County allegany
City or town Smithsburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 36 Stoper
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Adam Brown

3. (b) Social Security Number

none

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Mary Scott Brown
6.(c) If alive, give age 75 years
7. Birth date of deceased (mo., day, yr.) Jan 7 - 1857
8. AGE: Years 90 Months 2 Days 29 It less than one day hrs. min.

9. Birthplace Valle Summit - alleg - md.
(Town, county, and state)

10. Usual occupation retired

11. Industry or business merchant

12. Name Thomas Brown

13. Birthplace Scotland

14. Maiden name Agnes McCauley

15. Birthplace Scotland

16. Informant Mrs Adam Brown

Address Smithsburg, md.

17. Burial Date thereof April 7 - 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or M.E. - Valle Summit

Location Valle Summit, md.

18. Funeral director J. J. Buss

Address Smithsburg, md.

19. 4-7 is 47 Mrs. Nancy A. Ree
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 19 47 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 47 to April 5 19 47 and that I last saw him alive on Mar 1 19 47

Immediate cause of death Senility

Due to arterio sclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Mens of injury Injured at work?

23. SIGNATURE W. M. Lane Jr. MD

Address Smithsburg md. Date signed 4-7-47

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 9 1947
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

108

00537

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
In Police ambulance on way to
Memorial Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 184 Wineow
 (If rural, give LOCATION)
 2.(a) If veteran, name war.

3. (a) FULL NAME

James Thomas Brown

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male Colored Widower6. (b) Name of husband or wife Thelma Bates Brown

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4-19028. AGE: Years Months Days If less than one day
45 3 17 hrs. min.9. Birthplace Ridgeley, W. Va.
 (Town, county, and state)10. Usual occupation Laborer

11. Industry or business

12. Name James Brown
 13. Birthplace Pattersons Creek, W. Va.14. Maiden name Nellie Reubaum
 15. Birthplace Pattersons Creek, W. Va.16. Informant Mrs. Fred Hampton
 Address 1012 Rolling Mill Pl. Cumb. Md.17. Burial Date thereof Apr. 24, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Sumner Cem.Location Cumberland, Md.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.19. April 24 19 47 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 19 47 at 1.30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19
 and that I last saw him Dead April 21 19 47

Immediate cause of death

Lobar Pneumonia

DURATION

about 1
week

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Deputy Medical Examiner - Allegany Co.23. SIGNATURE H. V. Deming M.D. H. V. Deming
 M. D. or otherAddress Cumberland Md Date signed 4-24/47

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 29 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany
 City or town Route 6, Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Route 6, Cumberland
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)
 State Maryland County Allegany
 City or town Elkhart Mines, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

George M. Clise

3. (b) Social Security Number

none

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

May 28, 1878

6. (c) If alive, give age _____ years

8. AGE:

681018

It less than one day

hrs.

min.

9. Birthplace

Paris, Md. Allegany Co., Md.
(Town, county, and state)

10. Usual occupation

retired farmer

11. Industry or business

FATHER

12. Name

George Clise

13. Birthplace

Maryland

MOTHER

14. Maiden name

Larive Winters

15. Birthplace

Maryland

16. Informant

John Clise

Address

Narrow Park, Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Apr. 17, 1947
(month) (day) (year)

Cemetery or crematory

Allegany

Location

Frostburg, Md.

18. Funeral director

J. R. Wierst

Address

Frostburg, Md.

19. 4-17

(Date rec'd by registrar)

19. 47

Mrs. Henry N. Rao

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 19 47 at 7:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-yr. 19 46 to Apr 15 19 47
and that I last saw him alive on Apr 1 19 47

Immediate cause of death

thr myocarditis

DURATION

18 mo

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

WOM Clise MD
M. D. or other
Address Frostburg, Md. Date signed 4-16-47

RECEIVED
APR 22 1947
BUREAU # 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00539

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town 143 Wineow St. Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 weeksHospital, institution, or street address where death occurred:
143 Wineow St. Cumberland Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 143 Wineow St
(If rural, give LOCATION)2.(a) If veteran, name war World War I

3. (a) FULL NAME

Barton M. (Coleman) Coalman

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male colored Widower6. (b) Name of husband or wife Maggie Weelen

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 July 18828. AGE: Years Months Days If less than one day
64 9 2 hrs. min.9. Birthplace Pennsylvania
(Town, county, and state)10. Usual occupation laborer

11. Industry or business

12. Name unknown

13. Birthplace

14. Maiden name Sarah Lutz15. Birthplace Penna.16. Informant Mahek HolmesAddress 143 Wineow St. Cumberland Md17. Burial Date thereof April 8 1947
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Walden CemeteryLocation Cumberland Md.18. Funeral director Lewis Stein, Inc.Address Cumberland Md.19. April 7 47 J. P. Faulkner, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 19 47 2:50 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw him Dead April 4 19 47Immediate cause of death Carcinoma of the stomach
DURATION about 2 years

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. or otherAddress Cumberland Md Date signed 4/4/47

MARGIN RESERVED FOR BINDING

VS A15

9-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 15 1947

FBI

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00540

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County... Allegany
 City or town... Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 74 years
 Hospital, institution, or street address where death occurred:
6 Broadway
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... md. County... allegany
 City or town... Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 6 Broadway
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Martha Gertrude Conner

3. (b) Social Security Number

none

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) aug 2 - 1866 6.(c) If alive, give age years

8. AGE: Years 80 Months 8 Days 6 If less than one day
 hrs. min.

9. Birthplace... Keyser's Ridge, Garrett Co. Maryland
 (Town, county, and state)

10. Usual occupation... House Keeper

11. Industry or business

12. Name Levi Conner Born June 2-181113. Birthplace Cresaptown, Allegany Co. Maryland14. Maiden name Mary Ann Wiley Born July 27-182415. Birthplace Garrett Co. Maryland16. Informant Mrs. Walter JeffriesAddress Frostburg, md.17. Burial Date thereof... April 24 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Crantsville, Md.Location... Crantsville, Maryland.18. Funeral director... J. F. DennyAddress Frostburg, md.19. 4-23 1947 Mrs. Maury N. Roe

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1947 at 11:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

apr 20 1947 to apr 22 1947and that I last saw him alive on apr 21 1947

Immediate cause of death

SepticemiaDue to... arteriosclerosis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. M. LaneAddress Frostburg, Md. M. D. or otherDate signed 4-23-47

MARGIN RESERVED FOR BINDING

9-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 28 1947

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

00541

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

Allegany County InfirmaryHow long in hospital or institution? 4 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 205 Union St.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Rose Innse Connors

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Charles E. Connors

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 28, 1881

8. AGE:

66 Years2 Months20 Days

If less than one day

hrs. min.

9. Birthplace

Ireland

(Town, county, and state)

10. Usual occupation

Restaurant cook

11. Industry or business

12. Name Mack Mc Ginley

13. Birthplace

Ireland

14. Maiden name

Mary Dugan

15. Birthplace

Ireland

16. Informant

Allegany County Infirmary

Address

Cumberland, Md.17. Burial
(Burial, cremation, or removal. Which?)Date there April 21, 1947
(month) (day) (year)

Cemetery or crematory

Rose Hill Cem

Location

Thomas W. Co.

18. Funeral director

John J. Hahn

Address

Cumberland, Maryland19. April 20, 1947
(Date rec'd by registrar)J. P. Trautman, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18, 1947 at 6:00 a.m.

21. I CERTIFY that death occurred on the date stated; that I attended deceased from

Dec. 3, 1946 to Apr. 18, 1947and that I last saw her alive on Apr. 17, 1947

Immediate cause of death

Acute myocardial failure
Due to arterio-sclerotic cardio-
vascular disease

DURATION

5 min8 years

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Arthur F. Jones, M.D.

M. D. or other

Address 110 S. Centre St. Date signed 4-21-47

MARGIN RESERVED FOR BINDING

VS A15 9-4-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 29 1947
BUREAU V. N.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131a)

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany
 City or town Eckhart
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Eckhart
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Walter Edgar Connor

3. (b) Social Security Number

705-07-9677

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Nellie Connor
 7. Birth date of deceased (mo., day, yr.) February 24 1883
 8. AGE: Years 64 Months 1 Days 13 If less than one day _____ hrs. _____ min.

9. Birthplace Eckhart Allegany Md.
 (Town, county, and state)
 10. Usual occupation Mechanic Helper
 11. Industry or business B. + O. Shops
 12. Name Charles Connor
 13. Birthplace Scotland
 14. Maiden name unknown
 15. Birthplace _____

16. Informant Mrs. Joseph Apatos
 Address Frostburg, Md.
 17. Burial Date thereof April 9, 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Eckhart Cemetery
 Location Eckhart, Md.
 18. Funeral director J. R. Kewest
 Address Frostburg, Md.
 19. 4-9 19 47 McNaney & Roe
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 19 47 at 12:30 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 46 to April 7 19 47
 and that I last saw him alive on April 16 19 47
 Immediate cause of death Myocardial Infarction
C-V-Renal disease
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

DURATION

5 mos.2 yrs.

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE M. E. Yattens M.D.
 Address Frostburg, Md. Date signed 4/8/47

RECEIVED

APR 12 1947

BUREAU V A

Evidence for change of birthdate and age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-21

00543

FILM NO. G 110 MAY 8 1947

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County... Allegheny
City or town... Zeigler
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years
Hospital, institution, or street address where death occurred:
Zeigler Post 2 Freshing, Md.
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Md. County... Allegheny
City or town... Zeigler
(If outside city or town limits, write RURAL and give nearest town)
Street No. P.O. No 2 Freshing, Md.
(If rural, give LOCATION)
2. (a) if veteran, name war...

3. (a) FULL NAME

Bernardine Franklin Crane

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Emma Stokes
6. (c) If alive, give age 1858 years
7. Birth date of deceased (mo., day, yr.) March 23 - 1858

8. AGE: Years 79 Months 1 Days 3 If less than one day hrs. min.

9. Birthplace Mt. Savage, Md.
(Town, county, and state)

10. Usual occupation Retired Miner

11. Industry or business Coal Mines

12. Name Nathan Crane

13. Birthplace Maryland

14. Maiden name Wm. (Leont) R. Crane

15. Birthplace Leont R. Crane

16. Informant Mrs. Elsie Gignus

Address P.O. No 2 Freshing, Md.

17. Burial Date thereof 4-30-1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Methodist Cemetery

Location Mt. Savage, Md.

18. Funeral director David D. Waters

Address Freshing, Md.

19. 4-30 19 47 Mr. Nancy V. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 19 47 at 9:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19 46 to April 26 19 47

and that I last saw him alive on April 26 19 47

Immediate cause of death Cardio-Vascular Renal Disease DURATION 2 yrs.
with hypertension

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. G. Lattin M.D. M. D. or other

Address Freshing, Md. Date signed 4/29/47

MARGIN RESERVED FOR BINDING

VS A15 9.45 AM

VS A15 9.45 AM

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

RECEIVED

MAY 2 1947

BUREAU 7 6

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107

00544

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County Allegany
 City or town Lonaconing
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 mo 10 days
 Hospital, institution, or street address where death occurred:
L
 How long in hospital or institution? L

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Allegany
 City or town Lonaconing
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. church st
 (If rural, give LOCATION)
 2(a) If veteran, name war L

3. (a) FULL NAME

Carol Lee Crowe

3. (b) Social Security Number

L

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female white child

6. (b) Name of husband or wife L7. Birth date of deceased (mo., day, yr.) Dec. 17, 1946

8. AGE: Years Months Days If less than one day

3 17 hrs. min.

9. Birthplace Brooklyn, Allegany, md
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name George Shaw13. Birthplace unknown14. Maiden name Francis Crowe15. Birthplace Lonaconing, md16. Informant Francis CroweAddress Lonaconing, md17. Burial Date thereof April 4, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oak Hill CemeteryLocation Lonaconing, md18. Funeral director M. EichhornAddress Lonaconing, md19. April 4 1947 Jeanette M. Goal
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH April 4 1947, at 10 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 3 1947, to Apr 4 1947
 and that I last saw green Rx. did not see. 1947

Immediate cause of death

Bronchopneumonia

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Don Glorv M. D. or otherAddress Lonaconing Date signed 4/4/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED

APR 9 1947

WITHIN corporate limits
Mr. Davis

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 77 years.
Hospital, institution, or street address where death occurred:
323 Broadway
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 110 West Second Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Amos Middleton Davis

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Clara Bell Twigg

7. Birth date of deceased (mo., day, yr.) 20 October 1870

8. AGE: Year 76 Month 6 Day 5 It less than one day
hrs. min.

9. Birthplace Allegany County, Maryland.
(Town, county, and state)

10. Usual occupation Store Department

11. Industry or business B&O RR - Retired.

12. Name Francis Davis

13. Birthplace Maryland

14. Maiden name Irene Zimmerman

15. Birthplace Maryland.

16. Informant Mrs. Olive Sathoff
Address 110 W 2nd St., Cumberland, Md.

17. Burial Burial Date thereof 28 April 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Herman Cemetery
Location Near Cumberland, Md.

18. Funeral director Louis Stein, Inc.
Address Cumberland, Maryland.

19. April 26 1947 J. P. Faulkner, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 April 1947 19 at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 23 to April 25 1947
and that I last saw him alive on April 25 1947

Immediate cause of death Chronic
Valvular Heart Disease

Due to Myocarditis (Chronic)

Due to Coronary Sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE MED Owens, M.D. M. D. or other

Address 1332 Va ave Date signed 4/26/47

MARGIN RESERVED FOR BINDING

VS A15 9-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 3 1947

BUREAU

RECEIVED
APR 14 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

Reg. Dist. No. 00547 4

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7.5 yrs.
 Hospital, institution, or street address where death occurred:
37 Greene St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 37 Greene St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Anna Grady Deetz

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Robert R. Deetz
 6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Oct 30 1867

8. AGE: Years 79 Months 5 Days 14 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Wm H B Wilkinson

13. Birthplace Md.

14. Maiden name Anna Rebecca Smith

15. Birthplace Md.

16. Informant John Deetz
 Address Cumberland

17. Burial Date thereof April 16, '47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland

18. Funeral director Louis Stern Inc

Address Cumberland

19. April 15 1947 J. P. Faulkner, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 1947 at 4:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1945 to Apr. 14 1947

and that I last saw him/her alive on Apr. 14 1947

Immediate cause of death Myocardial infarction

DURATION

6 Mths.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE C. W. Sugar M. D. or other _____

Address Cumberland Md signed 4-15-47

MARGIN RESERVED FOR BINDING

VS A15 9-4 M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 22 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

00548

cb

9

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Allegheny
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Miners Hospital
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Michigan County Wayne
 City or town Detroit
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2544 Van Dyke
 (If rural, give LOCATION)
 2.(a) If veteran, name war. ☒

3. (a) FULL NAME

Mary Monahan

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Martin Monahan
 7. Birth date of deceased (mo., day, yr.) December 6, 1861 6.(c) If alive, give age _____ years
 8. AGE: Years 85 Months 4 Days 14 It less than one day _____ hrs. _____ min.

9. Birthplace Clarysville, Allegheny, Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John Smith

13. Birthplace Germany

14. Maiden name unknown

15. Birthplace

16. Informant Mrs. Annie Smeltz

Address Frostburg Md.

17. Burial Date of death Apr. 23, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Michaels

Location Frostburg Md.

18. Funeral director J. R. Riwert

Address Frostburg Md.

19. 4-22 1947 Mr. Harry N. Roe
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1947 at 11:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18 1947 to April 20 1947 and that I last saw him/her alive on April 20 1947

Immediate cause of death Cerebral Hemorrhage

DURATION

3 days

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. E. Gattens MD.

Address Frostburg Md. Date signed 4/22/47

M. D. or other _____

Address _____ Date signed _____

MARGIN RESERVED FOR BINDING

I

VS A15

9-45-45M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

RECEIVED
APR 24 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 4

00549

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 80 yrs
 Hospital, institution, or street address where death occurred:
615 Sylvan Ave
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State md County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 615 Sylvan Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Wm Carl Dreyer

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Margaret Reynolds
 6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Oct 17, 1867
 8. AGE: Years 80 Months 6 Days 4 It less than one day _____ hrs. _____ min

9. Birthplace Cumberland Allegheny Co Md
 (Town, county and state)

10. Usual occupation Retired

11. Industry or business Carpenter + Pattern Maker

12. Name Wm Frederick Dreyer

13. Birthplace Germany

14. Maiden name Margaret Barth

15. Birthplace Germany

16. Informant Harold Dreyer
 Address 819 Maplewood Lane Cumberland

17. Burial Trinity Lutheran Cemetery
 (Burial, cremation, or removal. Which?) Date thereof Apr 24, 1947
 (month) (day) (year)
 Cemetery or crematory Cumberland Md
 Location John J. Hafer

18. Funeral director John J. Hafer
 Address Cumberland Md

19. Date rec'd by registrar April 23, 1947
 Registrar Joe P. Franklin, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 19 47 at 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 18 19 47 to Apr. 21 19 47
 and that I last saw him alive on Apr. 18 19 47

Immediate cause of death Myocardial failure DURATION 3 hrs

Due to Chronic myocarditis

(fibrillation)

Due to debility

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Arthur F. Jones M.D.
 M. D. or other _____

Address 110 S. Centre St. Date signed 4-22-47

115 24th Ave
Cleveland
Ohio

115 24th Ave
Cleveland
Ohio

115 24th Ave
Cleveland
Ohio

115 24th Ave
Cleveland
Ohio

115 24th Ave
Cleveland
Ohio

115 24th Ave
Cleveland
Ohio

115 24th Ave
Cleveland
Ohio

APR 29 1947

BUREAU 7 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

00550

4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 42 yrs

Hospital, institution, or street address where death occurred:

502 Montreal Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 502 Montreal Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mr Wm Ralph Durbin

3. (b) Social Security Number

705-05-5343

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Augusta Heintzling6. (c) If alive, give age 360 years

7. Birth date of

deceased (mo., day, yr.)

June 30, 1888

8. AGE:

Years 58 Months 9 Days 6 hrs. min.

9. Birthplace

Gaithersburg, Montgomery Co, Md.
(Town, county, and state)

10. Usual occupation

General Foreman

11. Industry or business

B & O Railroad

12. Name

John Henry Durbin

13. Birthplace

Gaithersburg, Md.

14. Maiden name

Mary Hannah

15. Birthplace

Gaithersburg, Md

16. Informant

Mr Wm R. Durbin

Address

502 Montreal Ave - Cumberland

17. Burial

(Burial, cremation, or removal. Which) Date thereof Apr 8, 1947
(month) (day) (year)

Cemetery or crematory

Stillcrest Cemetery

Location

Cumberland, Md.

18. Funeral director

John J. Haffer

Address

Cumberland Md

19. April 7, 47

(Date rec'd by registrar)

19. 47

J. P. Franklin, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1947 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw him..... alive on 19.....

Immediate cause of death

Coronary Thrombosis(Pronounced SSB)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

injured at work?

23. SIGNATURE

Cliff. J. J. J.Address Cumberland M. D. or other 4/7/47

Date signed

505 West 1st St
Cumberland
Allegany

505 West 1st St
Cumberland
Allegany

The Hon. Ralph A. Rankin

April 6 1947

White House
Washington D.C.
368

June 30

RECEIVED
APR 15 1947
U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

505 West 1st St
Cumberland
Allegany
June 30 1947
505 West 1st St
Cumberland
Allegany
June 30 1947
505 West 1st St
Cumberland
Allegany
June 30 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL Hospital
13 DAYS

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 604 N. MECHANIC ST.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

JOHN E. EVERSTINE

3. (b) Social Security Number

None

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife ISABELLE MCCORMICK6. (c) If alive, give age 60 years

7. Birth date of

deceased (mo., day, yr.) 11/29/71

8. AGE:

Years

Months

Days

If less than one day

7547

hrs.

min.

9. Birthplace

Cumberland, Maryland

(Town, county, and state)

10. Usual occupation

CABINET MAKER - Retired

11. Industry or business

FATHER
MOTHER12. Name GEORGE W. EVERSTINE

13. Birthplace

MARYLAND

14. Maiden name

CLARA VALENTINE

15. Birthplace

MARYLAND

16. Informant

Mrs. Isabelle Everstine

Address

604 N. Mechanic St., Cumberland

17. Burial

Date thereof Apr. 9, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Rose Hill Cem.

Location

Cumberland, Md.

18. Funeral director

Charles L. George

Address

Cumberland, Md.19. April 9, 47
(Date rec'd by registrar)19. 47J. P. Franklin, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 6 1947 at 9:35 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him... alive on 19...

Immediate cause of death

DURATION

Mesmia3 months

Due to

Hypertension C.V. disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

B. M. Johnson
41 E. 1st St.
Date signed April 6, 1947

M. D. or other

Address

MARGIN RESERVED FOR BINDING

VS A15 9-4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 15 1947
BUREAU 8

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 1700
CERTIFICATE OF DEATH

00552
4
Reg. Dist. No.

1. PLACE OF DEATH:
County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 3 hours
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? About 3 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 720 Lafayette Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME Ella Orpha Flanagan Flanigan
3. (b) Social Security Number 235-14-1782

4. Sex female
5. Color or race white
6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Austin Flanigan
6. (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) July 31 1900

8. AGE: Years 46 Months 8 Days 19 If less than one day hrs. min.

9. Birthplace Davis Grant Co., West Virginia
(Town, county, and state)

10. Usual occupation Kitchen

11. Industry or business Memorial Hospital

12. Name Hettie Nine
13. Birthplace Davis W. Va.

14. Maiden name Susan Wolford
15. Birthplace Canan Valley W. Va.

16. Informant Austin Flanigan
Address 720 Lafayette Ave, Cumberland, Md.

17. Burial Date thereof 4/22/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Zion Memorial Cemetery
Location Cumberland, Md.

18. Funeral director William H. Kight
Address Cumberland, Md.

19. April 22, 47
(Date rec'd by registrar)
Registrar J. P. Franklin, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 19 47 at 2:50 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19 to 19 and that I last saw her Dead April 20 19 47

Immediate cause of death Intercranial hemorrhage
DURATION 3 1/2 hours

Due to fracture of the skull

Due to hit by an automobile

Other conditions fracture right humerous middle third.
(Include pregnancy within 3 months of death)

Major findings of operations hit by an auto. Date of op. 4-19-47

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 4-19-47

Where did injury occur? Cumberland Allegany Md
(City or town) (County) (State)
Va. Ave in front of B&O M.C.A.

Injured at home, farm, industry, public place (where?) highway
Means of injury hit by an auto. Injured at work? no

Deputy Medical Examiner Allegany

23. SIGNATURE H. V. Deming M.D.
M. D. or other H. V. Deming M.D.
Address Cumberland Md Date signed 4-22-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-68

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 29 1947
BUREAU V B

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 63-2

00553

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Rural Valley Rd. Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 6 months
Hospital, institution, or street address where death occurred:
Valley Road Box 436, R.F.D. #3
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany
City or town Rural Valley Rd. Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. Box 436, R.F.D. #3
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME

Mrs. Estella Marion Flettermann

3. (b) Social Security Number

None

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Karl E. Flettermann
6.(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) August 15 1897

8. AGE: Years 49 Months 8 Days 14 If less than one day hrs. min.

9. Birthplace Little Oreleans, Allegany Co., Md
(Town, county, and state)

10. Usual occupation House

11. Industry or business

FATHER 12. Name Frederick Sweitzer

13. Birthplace Little Oreleans, Md

MOTHER 14. Maiden name Sarah Apple

15. Birthplace Little Oreleans, Md.

16. Informant Karl E. Flettermann

Address Valley Road Box 436, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof May 1, 1947
(month) (day) (year)

Cemetery or crematory St Mary Cemetery

Location Cumberland, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. (Date rec'd by registrar) May 1, 1947 J.P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 19 47 at 4 A. M about

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw her alive Dead April 29 19 47

Immediate cause of death Acute dilatation of the heart DURATION at once

Due to

Due to

Other conditions Goiter several years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D. M. D. or other

Address Cumberland Md Date signed 4/29/47

MARGIN RESERVED FOR BINDING

I

VS A15 9.47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 3 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 years
 Hospital, institution, or street address where death occurred:
236 Park Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 236 Park Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Edna Blizzard Folmer

3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Lewis Folmer
 6. (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) 28 July 1898

8. AGE:	Years	Months	Days	If less than one day
	<u>48</u>	<u>8</u>	<u>3</u> hrs. min.

9. Birthplace West Virginia
 (Town, county, and state)
 10. Usual occupation housewife
 11. Industry or business

MOTHER FATHER

12. Name Martin Blizzard
 13. Birthplace West Va.
 14. Maiden name Lila Rigglesman
 15. Birthplace West Va.

16. Informant Lewis Folmer
 Address 236 Park St, Cumberland, Md.
 17. Burial Date thereof April 4, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Zion Memorial Park
 Location Belford Road Cumberland, Md.
Louis Stein Inc.
 18. Funeral director
 Address Cumberland, Md.
 19. April 3, 47 J. P. Faulkner, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1947 at 4:00 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 31, 1947 to April 1, 1947
 and that I last saw him alive on March 31, 1947
 Immediate cause of death Broncho-Pneumonia
 DURATION 14 days
 Due to

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

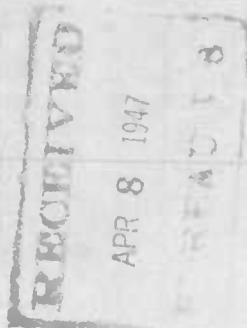
23. SIGNATURE B. M. Schindler, M.D.
 Address 41 Green St. Date signed April 11, 1947

MARGIN RESERVED FOR BINDING

VS 914 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Schindler



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

00555

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 75 yrs.
Hospital, institution, or street address where death occurred:
120 Greene St.
How long in hospital or institution? 7

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 120 Greene St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Joseph W. Footer

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Daisy Wolf
6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Oct 29 1868
8. AGE: Years 78 Months 5 Days 16 It less than one day hrs. min.

9. Birthplace Leeds, England
(Town, county, and state)

10. Usual occupation Partner - Retired

11. Industry or business Channing and Dye Works

12. Name Thomas Footer

13. Birthplace England

14. Maiden name Elizabeth Booth

15. Birthplace England

16. Informant Mrs John Brenneeman

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Apr 17 '47
(month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland

18. Funeral director Lans Stein Inc

Address Cumberland

19. April 17, 47 Registrar J. P. Franklin, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 15 19 47 at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-1-46 19 to 4-15-47 19

and that I last saw him alive on 4-15-47 19

Immediate cause of death Coronary occlusion

DURATION

6 1/2 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Franklin, M.D. M. D. or other

Address Cumberland Md Date signed 4-16-47

MARGIN RESERVED FOR BINDING

VS A15 9-4-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 22 1947
BUREAU V A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00556
Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 Years 11 Mo 21 Days
Hospital, institution, or street address where death occurred:
3 Race Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3 Race Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

George Korn's Garvin

3. (b) Social Security Number

217-10-5603

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
6. (b) Name of husband or wife <u>Ruth Damm Garvin</u>		
7. Birth date of deceased (mo., day, yr.) <u>April 22 1913</u>		
8. AGE: Years <u>33</u>	Months <u>11</u>	Days <u>21</u> If less than one day hrs. min.

8. Birthplace Cumberland, Allegany Co., Maryland
(Town, county, and state)

10. Usual occupation Spinner

11. Industry or business Celenese Corporation

12. Name Jesse Garvin

13. Birthplace McKeesport, Pa

14. Maiden name Elizabeth Korn's

15. Birthplace Cumberland, Md.

16. Informant Mrs Ruth Garvin

Address 3 Race St, Cumberland, Md.

17. Burial Date thereof April 16, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Zion Memorial Cemetery

Location Cumberland, Md.

18. Funeral director William H. Right

Address Cumberland, Md.

19. April 15, 47 18. J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 19 47 at 11- A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 24 19 47 to Apr. 13 19 47
and that I last saw him alive on Apr. 13 19 47

Immediate cause of death

Fracture of
testicle

Due to

General Metastasis

Due to

Other condition

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations

As above Date of op. Mar. 1946

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

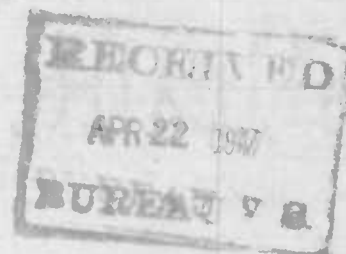
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Clayton J. J. J. M. D. or other
Cumberland Date signed 4/15/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00557

CERTIFICATE OF DEATH

Reg. Dist. No. 4

DR CAWLEY

1. PLACE OF DEATH:

County.....ALLEGANY

City or town.....CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....SEVEN DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?.....SEVEN DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....MARYLAND County.....ALLEGANY

City or town.....FROSTBURG
(If outside city or town limits, write RURAL and give nearest town)Street No. 31 GRANT ST FROSTBURG
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

MISS BESSIE GEHAUF

3.(b) Social Security Number

none

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

FEMALE WHITE SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age.....years

7. Birth date of
deceased (mo., day, yr.)

MARCH 16, 1884

8. AGE: Years Months Days If less than one day

63 1 0 hrs. min.

9. Birthplace.....MARYLAND
(town, county, and state)

10. Usual occupation.....SCHOOL TEACHER

11. Industry or business.....PUBLIC SCHOOL

12. Name.....GEHAUF, JOHN

13. Birthplace.....MARYLAND

14. Maiden name.....HENSEY, MINNIE

15. Birthplace.....MARYLAND

16. Informant.....BERNARD GEHAUF

Address.....FROSTBURG, MD.

17. BURIAL Date thereof APR. 19 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....ZION EVANGELICAL

Location.....FROSTBURG, MD.

18. Funeral director.....J. R. DURST

Address.....FROSTBURG, MD.

19. April 17, 1947 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....APRIL 16 1947, at 10:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

APRIL 10 1947 to APRIL 16 1947

and that I last saw him alive on.....APRIL 16 1947

Immediate cause of death

METASTATIC CARCINOMA,
BOTH LUNGS

Due to

MALIGNANT THYROID

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

No Operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE.....

Memorial Hospital Cumberland Md

M.D. or other

Address..... Date signed.....4-16-47

MARGIN RESERVED FOR BINDING

VS A15

9-4-47 M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED

APR 22 1947

BUREAU # 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1226

00558

Reg. Dist. No. 4

CERTIFICATE OF DEATH

DR. ENFIELD

1. PLACE OF DEATH:

County.....ALLEGANY
 City or town.....CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....24 YEARS
 Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
 How long in hospital or institution?.....7 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:-

(For newborn infants give residence of mother)

State.....MARYLAND County.....ALLEGANY
 City or town.....CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....407 WASHINGTON STREET
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

MR. STEPHEN M. GOGGIN

3. (b) Social Security Number

705-05-4523

4. Sex.....MALE 5. Color or race.....WHITE 6.(a) Single, married, widowed, or divorced.....WIDOWER
 6.(b) Name of husband or wife.....LULU BURKHOLDER
 7. Birth date of deceased (mo., day, yr.).....MARCH 11, 1877 6.(c) If alive, give age..... years
 8. AGE: Years.....70 Months.....1 Days.....7 If less than one day..... hrs. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH.....APRIL 18 19.....47 at.....7:56 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 14 19.....47 to April 18 19.....47
 and that I last saw him alive on April 18 19.....47

Immediate cause of death.....Colo. of sigmoid
 Due to.....
 Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....Colo. of sigmoid
 Date of op.....April 16, 47

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town)..... (County)..... (State).....
 Injured at home, farm, industry, pub'c place (where?).....
 Means of injury..... Injured at work?.....

23. SIGNATURE.....A. C. Enfield M. D. or other.....
 Address.....Cumberland Date signed.....4/19/47

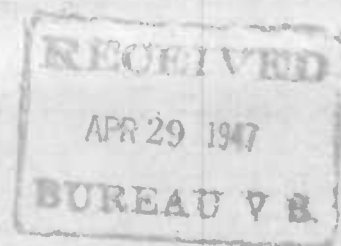
9. Birthplace.....VIRGINIA
 (Town, county, and state)
 10. Usual occupation.....BOILER MAKER
 11. Industry or business.....B & O T.P.
 12. Name.....WILLIAM GOGGIN
 13. Birthplace.....VIRGINIA
 14. Maiden name.....BURROUGHS, ELLEN A.
 15. Birthplace.....VIRGINIA
 16. Informant.....MEMORIAL HOSPITAL
 Address.....CUMBERLAND, MARYLAND
 17. Burial Date thereof.....April 21, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory.....Evergreen Burial Park
 Location.....Roanoke, Va.
 18. Funeral director.....John J. Hefner
 Address.....Cumberland, Md.
 19. April 20 19.....47 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15

9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH:

County Allegany
City or town Barrellsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Barrellsville

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Barrellsville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

CHARLES EDWARD GRAY

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Elizabeth Connor

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) 13 August 1873

8. AGE: Years 73 Months 8 Days 12 It less than one day
..... hrs. min.

9. Birthplace Kennells Mills, Penna.
(Town, county, and state)

10. Usual occupation Coal Miner

11. Industry or business

FATHER 12. Name George Gray
13. Birthplace Pennsylvania.

MOTHER 14. Maiden name Elizabeth Bloom
15. Birthplace Pennsylvania.

16. Informant Mrs. Esther Graham
Address Barrellsville, Maryland.

17. Burial Date thereof 28 April 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Methodist Cemetery,

Location Mount Savage, Maryland.

18. Funeral director Louis Stein, Inc.

Address Cumberland, Maryland.

19. April 28, 1947 Jessie McDermott
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25, 19 47 at 2:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22 19 47 to April 25 19 47 and that I last saw him alive on April 25 19 47

Immediate cause of death Chronic pulmonary disease
Chronic Bronchitis
Hypertension
Coronary Artery Disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE David Treest M. D. or 1080a Ave
Address..... Date signed 4/26/47

RECEIVED

MAY 2 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 14

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 days

Hospital, institution, or street address where death occurred:

Allegheny Hospital
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penn. County BedfordCity or town Bedford Valley Pa.
(If outside city or town limits, write RURAL and give nearest town)Street No. Route 700
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Helen V. Crowden

3. (b) Social Security Number

None4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Vernon H. Crowden

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) April 13 18998. AGE: Years 48 Months - Days 15 hrs. _____ min.9. Birthplace Bedford Valley Pa.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Wesley B. Hite13. Birthplace Pa.14. Maiden name Dixmier15. Birthplace Pa.16. Informant Vernon H. CrowdenAddress Bedford Valley Pa.17. Burial Date thereof Apr 30 47
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory P.O.S. 700 Cem.Location Centerville Pa.18. Funeral director Louis Stein IncAddress Cumberland19. April 30, 19 47 J. P. Traubler, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 28 19 47 at 6 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16 19 47 to April 18 19 47and that I last saw him alive on April 28 19 47

Immediate cause of death _____ DURATION _____

Meningitis, tubercu. 1Due to Lungs

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

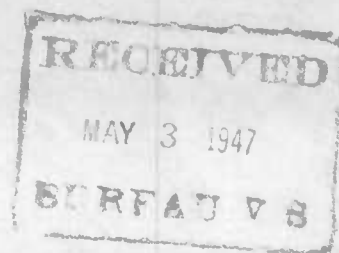
Means of injury _____ Injured at work? _____

23. SIGNATURE J. Bailey Hunter MD M. D. or other _____Address Cumberland Md. Date signed 4/29/47

MARGIN RESERVED FOR BINDING

VS A15 9-45 PM

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



DR. TOLSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 137-0

00561

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State WEST VIRGINIA County HampshireCity or town GREENSPRING
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

232-10-5586

3. (a) FULL NAME

MR. WILLIAM HAINES

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALEWHITEMARRIED6. (b) Name of husband or wife GERTIE GLAZE6. (c) If alive, give age 49 years7. Birth data of deceased (mo., day, yr.) AUGUST 6 18888. AGE: Years 58 Months 8 Days 23 If less than one day _____ hrs. _____ min.9. Birthplace WEST VIRGINIA Green Spring
(Town, county, and state)10. Usual occupation KOPPERS CO.

11. Industry or business

12. Name JOHN HAINES13. Birthplace WEST VIRGINIA14. Maiden name SARAH SMITH15. Birthplace WEST VIRGINIA16. Informant MEMORIAL HOSPITALAddress CUMBERLAND, MD.17. Burial Date thereof May 2, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Forest Glenn CemeteryLocation Green Spring, W. Va.18. Funeral director William H. KnightAddress Cumberland, Md.19. April 30, 1947 Registrar J. P. Franklin, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 29 1947 at 3:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-28-47 to 4-29-47 and that I last saw him alive on 4-28-47

Immediate cause of death

DURATION

Cerebral hemorrhage
Chronic nephritis with
hypertension
Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Cumberland, Md. Date signed 4-29-47

RECEIVED
MAY 3 1947
BUREAU

Within corporate limits

DR. RICHARD WILLIAMS MARYLAND STATE DEPARTMENT OF HEALTH

Evidence for the change of age is shown on 2411 N. Charles St., Baltimore

FILM No. G 109 APR 25 1947 CERTIFICATE OF DEATH

Reg. Dist. No. 00562 4

1. PLACE OF DEATH:

County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 Years
Hospital, institution, or street address where death occurred:
MEMORIAL
How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 501 BEALL STREET
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

WILLIAM HAYDEN

3. (b) Social Security Number

218-16-4591

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife WIFE CORRECTOR Lula Nelson Hayden

6. (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) JUNE 9, 1902

8. AGE: Years 44 Months 4 Days 10 If less than one day 6 hrs. min.

9. Birthplace Moundsville, Marshall Co., West Va.
(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business James Lynn Broker

12. Name Isaac Hayden

13. Birthplace Unknown

14. Maiden name Flora Bennigton

15. Birthplace Weston, W. Va.

16. Informant Mrs Wm B. Hayden

Address 501 Beall St, Cumberland, Md.

17. Burial Date thereof 4/17/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. April 17, 1947 J P Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 15 1947 at 10:45 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/14/47 to 4/15/47 and that I last saw him alive on 4/15/47

Immediate cause of death Myocardial Infarction - Rheumatic Fever

Due to Rheumatic Fever
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Richard Williams, M.D.
M. D. or other
Address Med Bldg Date signed 4/16/47

MARGIN RESERVED FOR BINDING

VS A15 9-47-55M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 22 1947
BUREAU

Within corporate limits. Evidence for the change of sex is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1190

00563

FILM No. G 112 SEP 8 1947

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Rawlings (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Thelma May Hise

3. (b) Social Security Number

None

4. Sex MALE
FEMALE 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1947
8. AGE: Years Months Days If less than one day
17 hrs. min.

9. Birthplace Rural Rawlings, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Adam Hise
13. Birthplace Burlington, W. Va.
MOTHER 14. Maiden name Mary Shaffer
15. Birthplace Rawlings, Md.

16. Informant Adam Hise
Address Rawlings, Md.

17. Burial Date thereof Apr. 30, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Dawson Family Cem.
Location Near Rawlings, Md.

18. Funeral director Charles L. George
Address Cumberland, Md.

19. April 30, 47 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 28, 19 47 at 11 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 19 47 to April 28 19 47
and that I last saw him alive on April 27 19 47

Immediate cause of death diarrhea
Tuberc. Pneumonia DURATION 17 days

Due to 9/8/47

Due to

Other conditions Her nephrodisia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Elizabet Brown M.D. M. D. or other

Address Rawlings Date signed 4/29

MARGIN RESERVED FOR BINDING

VS A15 9.45 AM

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Postmortem examination revealed child to be male. See letter in Per. file under
Brings. 9.6.47 pc. 9/8/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00564

UNDERTAKER THURSH AND SON
DR. WISEMAN

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State WEST VIRGINIA County MINERALCity or town KEYSER
(If outside city or town limits, write RURAL and give nearest town)Street No. RT. #3
(If rural, give LOCATION)2.(a) If veteran, name war ☒

3. (a) FULL NAME

MRS. GERTIE HOGBIN

3. (b) Social Security Number

Mrs.

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALE WHITE WIDOWED6. (b) Name of husband or wife Jessie Hogbin

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 18838. AGE: Years 63 Months 6 Days 28 If less than one day
hrs. min.9. Birthplace WEST VIRGINIA
(Town, county, and state)10. Usual occupation HOUSE WIFE

11. Industry or business

12. Name HARLEY POTTER13. Birthplace WEST VIRGINIA14. Maiden name MAGGIE RHODERICK15. Birthplace WEST VIRGINIA16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MARYLAND

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar) 19. Apr 24, 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 15 19 47 at 1:24 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 12 19 47 to April 15 19 47
and that I last saw him or alive on April 12 19 47

Immediate cause of death

Heart failure

DURATION

1 hourDue to Arteriosclerosis Heart Disease

Due to

Other conditions DiabetesRVL Pneumonia
(Include pregnancy within 3 months of death)10 y.15 days

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of Injury Injured at work?

23. SIGNATURE W. D. Wiseman M. D. or otherAddress Cresaptown, Md Date signed Apr 24, 1947

MARGIN RESERVED FOR BINDING

VS A15

9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 6 1947
BUREAU V B

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00565

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH:

County Maryland
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 36 Race St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Ernest Stephen Huth

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Rose A. Donahue Huth

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 5, 1869

8. AGE: Years 77 Months 11 Days 26 If less than one day hrs. min.

9. Birthplace Weston, W. Va.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Kline Furniture Store

12. Name Charles F. Huth

13. Birthplace Germany

14. Maiden name Rose Monahan

15. Birthplace Ireland

16. Informant Mrs. Phillip Murphy

Address 510 Sheridan Pl. Cumberland, Md.

17. Burial Date thereof Apr. 5, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Mary's Cem.

Location Cumberland, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. April 4, 47 Registrar J. P. Franklin, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 1, 18 47 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 no. 4 19 to 1 47 19 and that I last saw him alive on 29 no. 47 18

Immediate cause of death

Tuberculosis, pleurisy, advanced, bilateral

DURATION

2

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Alfred Van Alne M. D. or other

Address Cumberland, Md. Date signed 3 Apr. 47

MARGIN RESERVED FOR BINDING

VS 415 9.45

VS 415 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 8 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 938

CERTIFICATE OF DEATH

Reg. Dist. No. 00566 4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 22 yrs

Hospital, institution, or street address where death occurred:

218 Fulton St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 218 Fulton St.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Charles Taylor Dyer

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Bertha H. Holt6. (c) If alive, give age 64 years

7. Birth date of

deceased (mo., day, yr.)

May 15, 1880

8. AGE:

Years 66 Months 11 Days 0 If less than one day

9. Birthplace

Romney, Hampshire, W. Va.
(Town, county, and state)

10. Usual occupation

Retired Carpenter

11. Industry or business

W. Va. Railway

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Hampshire Co., W. Va.

18. Informant

Wm. Hare

Address

218 Fulton St.

17. (Burial, cremation, or removal. Which?)

Burial Date thereof Apr 18, 1947
(month) (day) (year)

Cemetery or crematory

Zion Baptist Church

Location

Cumberland Ind.

18. Funeral director

John J. Ayler

Address

Cumberland Ind.

19. (Date rec'd by registrar)

April 18, 1947 J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 19 47, at 6:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 13 19 43 to April 15 19 47and that I last saw him alive on April 15 19 47

Immediate cause of death

Hypostatic Pneumonia

Due to

Hyperinflation

Due to

Myocarditis

Other conditions

La GrippeCerebral Hemorrhage

(Include pregnancy within 3 months of death)

19 43

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

T. Bailey Hunter MDAddress Cumberland Ind. Date signed 4/16/47

APR 22 1947

UNEAT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00567
4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 years
 Hospital, institution, or street address where death occurred:
Allegany Hospital
 How long in hospital or institution? 20 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 343 Bedford St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

William Izat

3. (b) Social Security Number

214-01-3758

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Anna Young Izat
 6. (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) May 6, 1895

8. AGE: Years 51 Months 11 Days 0 If less than one day hrs. min.

9. Birthplace Conowingo, Allegany Co., Md.
 (Town, county, and state)

10. Usual occupation Deputy Sheriff

11. Industry or business Allegany Co. Ind.

12. Name Robert E. Spier Izat

13. Birthplace Scotland

14. Maiden name Jane Peel

15. Birthplace Scotland

16. Informant Paul Francis Izat

Address Baltimore, Md.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof April 8, 1947
 (month) (day) (year)

Cemetery or crematory Oak Hill Cemetery

Location Conowingo, Md.

18. Funeral director W. E. Eickhorst

Address Conowingo, Md.

19. April 8 19 47 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 19 47 at 12:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him Dead April 6 19 47

Immediate cause of death Coronary occlusion DURATION at once

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

Deputy Medical Examiner - Allegany

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
 M. D. April 6/47

Address Cumberland Md. Date signed April 6/47

MARGIN RESERVED FOR BINDING

VS-A15 9-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED

APR 15 1947

BT RFA

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164d

00568

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County AlleganyCity or town Frostburg Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 hours

Hospital, institution, or street address where death occurred:

Miner's HospitalHow long in hospital or institution? 7 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)Street No. 18 Church St.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Samuel James

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Jessie B. C. Millard6. (c) If alive, give age 72 years7. Birth date of deceased (mo., day, yr.) Jan. 31- 18738. AGE: Years 74 Months 2 Days 6 If less than one day
hrs. min.9. Birthplace Lonaconing, Allegany Co., Md.
(Town, county, and state)10. Usual occupation Coal Miner - Retired11. Industry or business I. C. Coal Co.12. Name James James13. Birthplace Wales14. Maiden name L15. Birthplace L16. Informant Hubert JamesAddress Lonaconing, Md.17. Burial (Burial, cremation, or removal, Which?) Date thereof April 10, 1947
(month) (day) (year)Cemetery or crematory Oak Hill CemeteryLocation Lonaconing, Md.18. Funeral director M. BickhamAddress Lonaconing, Md.19. 4-10 19 47 Mrs. Nancy N. Re
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH April 7 19 47 at 11.15 P21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 to 19
and that I last saw him alive on Dead April 7 19 47Immediate cause of death Exsanguination DURATION 11 Hrs.Due to Throat cut with a straight razor, wound self inflicted
Due to Despondent

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 4-7-1947Where did injury occur? Lonaconing Allegany Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) homeMeans of injury as above Injured at work? noDeputy Medical Examiner - Allegany23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or otherAddress Confluence, Md. Date signed 4/10/47

RECEIVED

APR 14 1947

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00569

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County... Allegany
 City or town... Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 19 47
 Hospital, institution, or street address where death occurred:
167 E Main St Frostburg Md
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Allegany
 City or town... Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 6 Bowery St
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Alfred Patterson Johnson

3. (b) Social Security Number

219-01-0337

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Jennie Johnson

6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Sept 28 1889

8. AGE: Years 57 Months 6 Days 12 If less than one day hrs. min.

9. Birthplace Lopez, Sullivan, Penna
 (Town, county, and state)

10. Usual occupation Insurance agent

11. Industry or business Zucker Insurance Co

12. Name unknown

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant Alfred L Johnson

Address 13417 Casper Rd Cleveland 10 Ohio

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof April 13 1947
 (month) (day) (year)

Cemetery or crematory Parsons Cemetery

Location Parsons W. Va.

18. Funeral director J. B. Whirist

Address Frostburg Md

19. 4-10 47 W. Xand N. Rae
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 19 47 at 8:56 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 5 19 47 to Apr 8 19 47

and that I last saw him alive on Apr 18 19 47

Immediate cause of death Coronary thrombosis

DURATION 2 hours

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. M. Lane Jr M.D.

Address Frostburg Md Date signed 4-9-47

MARGIN RESERVED FOR BINDING

9-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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APR 14 1947

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

144a

CERTIFICATE OF DEATH

00570
Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
City or town Pittsburgh
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
Allegheny Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Pa County Bedford
City or town Artzemas
(If outside city or town limits, write RURAL and give nearest town)
Street No. Star Route
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Mrs Beulah Mae Johnson

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Wm Ralph Johnson

7. Birth date of deceased (mo., day, yr.) Feb 7, 1910 6.(c) If alive, give age 36 years

8. AGE: Years 37 Months 2 Days 0 If less than one day hrs. min.

9. Birthplace Tucker County, W. Va
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business At Home

12. Name Robert D. Glass

13. Birthplace Tucker Co. W. Va

14. Maiden name Zora Johnson

15. Birthplace W. Va.

18. Informant Wm R. Johnson

Address Star Route, Artzemas Pa.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Apr 10, 1947
(month) (day) (year)

Cemetery or crematory St Stephen's Christian Cemetery

Location Near Artzemas Pa

18. Funeral director John J. Hoffer

Address Cumberland Md

19. April 10, 1947 J. P. Franklin, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7, 1947 at 5:57 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1, 1946 to April 7, 1947 and that I last saw him alive on April 5, 1947

Immediate cause of death ecclampsia DURATION 4 days

Due to pregnancy & toxemia

Due to

Other conditions

(Include pregnancy within 8 months of death)
Major findings of operations

Antopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. Whinn M.D. M. D. or other

Address 59 Queen St. Date signed 4-9-47

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Handwritten text at top left.

Handwritten text in the upper middle section.

Handwritten text in the upper right section.

Large block of handwritten text spanning the middle of the page.

01 **RECEIVED**
APR 15 1947

Handwritten text and stamps in the bottom right section, including the word **BURFA**.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00521 4

1. PLACE OF DEATH:

County... AlleganyCity or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 daysHospital, institution, or street address where death occurred:
Allegany HospHow long in hospital or institution? 3 days

3. (a) FULL NAME

Mary Frances Judy

3. (b) Social Security Number

None4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced S

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) April 7 19478. AGE: Years _____ Months _____ Days 3 If less than one day _____ hrs. _____ min.9. Birthplace Cumberland Allegany Co. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Paul Judy13. Birthplace Cumberland Md.14. Maiden name Anna E. Summers15. Birthplace Cumberland Md.16. Informant Mary JudyAddress 320 Independence St. Cumberland Md.17. Burial Date thereof 4/11/47
(Burial, cremation, or removal? Which?) (month) (day) (year)Cemetery or crematory Full Crest CemeteryLocation Cumberland Md.18. Funeral director William H. WrightAddress Cumberland Md.19. April 11, 1947 J. P. Franklin, M. D.
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 320 Independence St.
(If rural, give LOCATION)

2. (a) If veteran, name War _____

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1947 at 12 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 7 1947 to April 10 1947and that I last saw him alive on April 9 1947Immediate cause of death 6 mos pneumonia

DURATION

6 mos pneumoniaAsphyxia

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE F. Alan G. Mumford

M. D. or other

Address Cumberland Md. Date signed April 10 1947

MARGIN RESERVED FOR BINDING

VS-A15 9-4-45M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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APR 15 1947

BUREAU

[Faint, illegible handwritten notes and signatures]

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

00572

Reg. Dist. No. 4

DR. ELIASON

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 4 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County GARRETTCity or town OAKLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

BABY BOY KEIPER (PREMATURE)

3.(b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MALEWHITESINGLE (INFANT)

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) APRIL 22, 19478. AGE: Years Months Days If less than one day
4 hrs. min.9. Birthplace OAKLAND, MD. GARRETT
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name LEO P. KEIPER13. Birthplace PENNSYLVANIA14. Maiden name MARY NAIR15. Birthplace PENNSYLVANIA16. Informant MEMORIAL HOSPITALAddress CUMBERLAND, MD.17. Burial Date thereof April 27-1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory OaklandLocation Oakland md18. Funeral director Emory BolducAddress Oakland md19. April 26 19 47 J. L. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 26 19 47 at 12:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22 19 47 to April 26 19 47and that I last saw him alive on April 26 19 47Immediate cause of death Prematurity DURATIONof Mrs. delivery

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Dr. Eliasson M. D. or otherElmer N. Cumberland Date signed 4/26-47

MARGIN RESERVED FOR BINDING

VS A15 9.41

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 3 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

00573

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 300 Massachusetts Avenue
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Baby Boy Keiter

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife
 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) April 13, 1947

8. AGE: Years Months Days If less than one day
3 hrs. 3 min.

9. Birthplace Cumberland, Allegany County, Maryland
 (Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Ralph Edward Keiter
 13. Birthplace West Virginia
 14. Maiden name Jean Rose Williams
 15. Birthplace Ohio

16. Informant Mr. Ralph E. Keiter
 Address 300 Massachusetts Ave.

17. Burial Date thereof April 15, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cem.
 Location Cumberland, Md.

18. Funeral director Louis Stein, Inc.
 Address Cumberland, Md.

19. April 15, 1947 J. P. Faulkner, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13, 1947 6:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 13, 1947 to Apr. 13, 1947
 and that I last saw Apr. 13, 1947 alive on Apr. 13, 1947

Immediate cause of death Myocarditis

DURATION

3 hrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

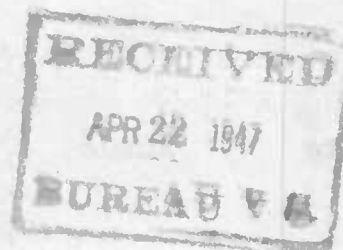
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clayton J. J. J. M.D. or other

Address Cumberland Date signed 4/15/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within separate limits
Evidence for change
of wife's age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

302

00574

FILM No. G 110 MAY 23 1947 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 47 Years
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? Five hours and 15 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County Allegany
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 324 FREDERICK STREET
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

PATRICK H. KENNEY

3. (b) Social Security Number

705-09-9364

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED

B. (b) Name of husband or wife NELLIE BURNS

7. Birth date of deceased (mo., day, yr.) 2/28/88 1888 6. (c) If alive, give age 58 5/8 years

8. AGE: Years 59 Months 1 Days 8 hrs. 2 min.

9. Birthplace Windom, Mineral Co, West Va.
(Town, county, and state)

10. Usual occupation MACHINIST11. Industry or business Baltimore & Ohio Railroad12. Name PATRICK KENNEY13. Birthplace IRELAND14. Maiden name Bridgett MALLOY, ~~PHILLIPS~~15. Birthplace 1 MAY Bloomington, Md.16. Informant Mrs Patrick H. KenneyAddress 324 Frederick St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 4/9/47
(month) (day) (year)

Cemetery or crematory St Patricks CemeteryLocation Cumberland, Md.18. Funeral director William H. KightAddress Cumberland, Md.19. April 7 47 J. P. Frank Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 19 47 at 7:45 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3 19 47 to April 6 19 47and that I last saw him alive on April 6 19 47

Immediate cause of death Coronary - Vascular disease due to
arteriosclerosis DURATION 7 years

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. M. Franklin M. D. or otherAddress H. Green Date signed April 7 1947

RECEIVED

APR 15 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

§3a

00575

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH:

County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town PINTO, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

PEARL B. KNIERIEM

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALE WHITE MARRIED6. (b) Name of husband or wife EARL KNIERIEM7. Birth date of deceased (mo., day, yr.) 12/22/1892 6. (c) If alive, give age 54 years8. AGE: Years Months Days If less than one day
54 3 18 _____ hrs. _____ min.9. Birthplace PA.
(Town, county, and state)10. Usual occupation HWFE

11. Industry or business

12. Name CHARLES WERTZ13. Birthplace PA14. Maiden name Belle Valentine15. Birthplace Penna.16. Informant Mr. Earl KnieriemAddress Pinto, Maryland17. Burial Date thereof Apr. 12, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Menonite Cem.Location Pinto, Md.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.19. April 11, 1947 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APR. 10 1947 at 7:55A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
February 19 47 to April 10 19 47
and that I last saw her alive on 4-10 19 47Immediate cause of death Cerebro-vascularHemorrhage
Pulmonary Edema
Due to Hypertension, essentialDue to _____
Other conditions Cardiac Hypertrophy

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____
Autopsy results Subarachnoid Hemorrhage

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Franklin M. D. or other _____Address Crescentown, Md Date signed 4/10/47

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 15 1947

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00576
Reg. Dist. No.

1. PLACE OF DEATH:
County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
In route to Allegany Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 721 Maryland Ave.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME
Harry Samuel Lamm
3. (b) Social Security Number
705-05-5169

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife Paul Winbrough Lamm

7. Birth date of deceased (mo., day, yr.) April 26 1892
8. AGE: Years 54 Months 11 Days 6 If less than one day
hrs. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual occupation Supervisor
11. Industry or business B & D Railroad Co.

FATHER
12. Name William Lamm
13. Birthplace Maryland
MOTHER
14. Maiden name Sadie McClain
15. Birthplace Maryland

16. Informant Paul Winbrough Lamm
Address 721 Maryland Ave. Cumberland Md
17. Interment - Crypt Date thereof April 5, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Cumberland, Md.

18. Funeral director Louis Stein Inc.
Address Cumberland, Md.
19. April 3, 47 Registrar J. P. Franklin, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION
20. DATE OF DEATH April 2 1947 at 10:30 AM
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
and that I last saw him Dead April 2 1947

Immediate cause of death
Coronary occlusion
DURATION
at once
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
Deputy Medical Examiner - Allegany Co.
23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
Address Cumberland, Md. Date signed April 2/47

MARGIN RESERVED FOR BINDING

VS 410 9-410

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED

APR 8 1947

BUREAU

Outside of
City limits

Richard Wms

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

00577

4

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
City or town near Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 yrs
Hospital, institution, or street address where death occurred: Private Ind.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County Allegany
City or town near Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Private
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Mrs Caroline Lewis

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Edmond Lewis

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 14 1865

8. AGE: Years 81 Months 3 Days 19 hrs. min.

9. Birthplace England
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business At Home

12. Name Edward Harrison

13. Birthplace England

14. Maiden name Caroline (Harrison)

15. Birthplace England

16. Informant Mrs Eliza Wells

Address 530 Reel Ave - Camb Ind.

17. Burial (Burial, cremation, or removal) Which? Burial Date thereof Apr 6, 1947
(month) (day) (year)

Cemetery or crematory Wildcrest Cemetery

Location Cumberland Ind.

18. Funeral director John J. Stafe

Address Cumberland Ind.

19. Date rec'd by registrar April 6 1947 Registrar J. P. Franklin, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 3 19 47 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 10, 1946 to April 3, 1947

and that I last saw her alive on April 3, 1947

Immediate cause of death

Chronic Myocarditis

Due to

degenerative disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. B. Williams, M.D.

Address Cumberland Ind. Date signed 4/6/47

MARGIN RESERVED FOR BINDING

I

9-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

Address.....

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 18 1947

BUREAU 68

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

CERTIFICATE OF DEATH

Reg. Diat. No. 14

00579

1. PLACE OF DEATH:

County Allegheny
City or town Ellerslie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegheny
City or town Ellerslie
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

George W. Lowery

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Lillie Luman

6. (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1866

8. AGE: Years 80 Months 7 Days 17 hrs. min.

9. Birthplace Hyndman R.D. Pa.
(Town, county, and state)

10. Usual occupation Lab. or

11. Industry or business

12. Name John W. Lowery

13. Birthplace Pa.

14. Maiden name Lydia Sheier

15. Birthplace Pa.

16. Informant Alden Lowery

Address Ellerslie, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof May 2, 1947
(month) (day) (year)

Cemetery or crematory Coke's Mees

Location Hyndman R.D. Pa.

18. Funeral director Harvey H. Zeigler

Address Hyndman Pa.

19. May 2 47 Registrar J. Lloyd Wolfe

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/29 19 47 at 2 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/19 19 47 to 4/29 19 47

and that I last saw h. f. a. alive on 4/29 19 47

Immediate cause of death Chronic Arterio-Sclerosis

Due to Cerebro-vascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE John A. Fopper

Address Hyndman Pa.

Date signed 4/30/47

DURATION

10 yrs.

MARGIN RESERVED FOR BINDING

I

VS A15 9-4

VS A15 9-4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 5 1947
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

00580

10

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County AlleganyCity or town Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Moses Elmer Lowery

3. (b) Social Security Number

none

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife

Mary Lowery

7. Birth date of deceased (mo., day, yr.)

October 2, 1865

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

81617

hrs.

min.

9. Birthplace

Pennsylvania
(Town, county, and state)

10. Usual occupation

retired laborer

11. Industry or business

brickyard

FATHER

12. Name

Anthony Lowery

13. Birthplace

Pennsylvania

MOTHER

14. Maiden name

Smithy Dicken

15. Birthplace

Pennsylvania

16. Informant

Walter Lowery

Address

Washington Pa.

17.

(Burial, cremation, or removal, Which?)

Date thereof April 23 - 47
(month) (day) (year)

Cemetery or crematory

Methodist Cemetery

Location

Mt. Savage Md.

18. Funeral director

J. R. Dewart

Address

Droptburg Md.

19.

Apr. 22
(Date rec'd by registrar)Veronica M. Dermott
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19th 1947 at 6:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 12 1947, to April 19 1947
and that I last saw him alive on April 19 1947

Immediate cause of death

Myocarditis.

DURATION

Several
months.

Due to

Effer's pneumonia
Bronchial asthma

Due to

Other conditions

Chronic Bronchial
asthma.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William E. Moseley M.D.
M. D. attending

Address

Mt. Savage Md.

Date signed

4/20/1947

MARGIN RESERVED FOR BINDING

VS A15

9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 28 1947

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore MD

00581

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegheny Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residences of mother)State MD County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 406 1/2 Furnace St.
(If rural, give LOCATION)2.(c) If veteran, name war World War I

3. (a) FULL NAME

Felix Gregory Manthey

3. (b) Social Security Number

705-05-4390

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife

Clara Free

6. (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) Jan 16, 1891

8. AGE: Years 56 Months 2 Days 17 hrs. min.

9. Birthplace Cumberland Allegheny Co., Md.
(Town, county, and state)10. Usual occupation Store Helper11. Industry or business B & O Railroad12. Name John Manthey13. Birthplace Germany14. Maiden name Mary Sturf15. Birthplace Germany16. Informant Mrs. Felix G. MantheyAddress 406 1/2 Furnace St. Cumberland, Md.17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year) Apr 7, 1947Cemetery or crematory St Peter & Paul CemeteryLocation Cumberland, Md.18. Funeral director John J. HalerAddress Cumberland, Md.19. Date rec'd by registrar April 7, 1947 Registrar Joseph C. Zuph

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1947 at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 31, 1947 to April 3, 1947
and that I last saw him alive on 4/3/47

Immediate cause of death

acute pneumonia
secondary to chronic
suppuration

DURATION

Due to

Other conditions

(Includes pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE

John K. Rozum M.D.
Address Cumberland, Md. Date signed 4/6/47

MARGIN RESERVED FOR BINDING

VS A15 9-4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Handwritten notes at the top left of the page, including the word "proposed" and some illegible scribbles.

Handwritten notes at the top right of the page, including the word "proposed" and some illegible scribbles.

Handwritten notes in the upper middle section of the page.

Handwritten notes in the middle section of the page.

Handwritten notes on the left side of the middle section, including the word "large".

Handwritten notes on the right side of the middle section.

Handwritten notes below the middle section.

Handwritten note on the far right edge of the page.

RECEIVED
APR 15 1947

Handwritten notes at the bottom of the page, including the word "proposed" and some illegible scribbles.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160a

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 days

Hospital, institution, or street address where death occurred:

Allegany HospitalHow long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 948 Maryland Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Sharon Rebecca Mason

3. (b) Social Security Number

None4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29, 19478. AGE: Years Months Days If less than one day
4 hrs. min.9. Birthplace Cumberland, Allegany Co Maryland
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name William Robert Mason13. Birthplace Cumberland, Md.14. Maiden name Norma J. Hamilton15. Birthplace Cumberland, Md.16. Informant William Robert MasonAddress Cumberland, Md.17. Burial Date thereof April 4, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Mary's CemeteryLocation Cumberland Md.18. Funeral director Louis Stein, Inc.Address Cumberland, Md.19. April 3, 47 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 April 19 47 at 12:02 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from

3-29-47 to 4-2-47
and that I last saw him alive on 2-1-47

Immediate cause of death

intracranial hemorrhage
Due to biroth poisoning

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address St. George St. Date signed 4-2-47

MARGIN RESERVED FOR BINDING

VS-A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

Dr. J. Briggs
all 9-00582
4

RECEIVED

APR 8 1947

REAR 18

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

00583

1. PLACE OF DEATH:

County AlleganyCity or town Summersburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

Allegany County Infirmary

How long in hospital or institution?

2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Priscilla Mathias

3. (b) Social Security Number

none

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

FemaleWhiteSingle

6. (b) Name of husband or wife

6. (c) If alive, give age

7. Birth date of

deceased (mo., day, yr.)

November 9, 1861

8. AGE:

85

Years

5

Months

14

Days

If less than one day

hrs.min.

9. Birthplace

Wales
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

MOTHER FATHER

12. Name

William Mathias

13. Birthplace

Wales

14. Maiden name

Katherine Thomas

15. Birthplace

Wales

16. Informant

Mrs. Stanley Shideester

Address

Frostburg, Md.

17. Burial (Burial, cremation, or removal, Which?)

Date thereof Apr. 25 '47
(month) (day) (year)

Cemetery or crematory

Allegany Cemetery

Location

Frostburg, Md.

18. Funeral director

J. R. Durst

Address

Frostburg, Md.19. April 25, 1947
(Date rec'd by registrar)J. P. Traulhi, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 23 1947 at 11:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 3 1946 to Apr. 23 1947and that I last saw her alive on Apr. 22 1947

Immediate cause of death

Myocardial failure

DURATION

3 hrs.Due to Chronic myocarditis10 yrs.Due to Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Arthur F. Jones, M.D.

M. D. or other

Address 110 S. Centre St.Date signed 4-26-47

MARGIN RESERVED FOR BINDING

VS A15

9.4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED

APR 29 1947

BUREAU OF

Dr. Grove

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-2

00584

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 Years
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 411 Franklin Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mr. Harry McCullough, Sr.

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married6. (b) Name of husband or wife Mary Jeffries
6. (c) If alive, give age 65 years7. Birth date of deceased (mo., day, yr.) April 5, 1873
8. AGE: Years Months Days It less than one day
74 0 22 hrs. min.9. Birthplace Pennsylvania
(Town, county, and state)10. Usual occupation Retired11. Industry or business Furniture Store12. Name Henry Clay McCullough13. Birthplace Maryland14. Maiden name Katherine Leighty15. Birthplace Pennsylvania16. Informant Memorial HospitalAddress Cumberland, Maryland17. Burial Date thereof April 30, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Addison CemeteryLocation Addison, Pennsylvania18. Funeral director William H. KightAddress Cumberland, Md.19. April 30 1947 J. P. Franklin, Jr.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27, 1947 at 9:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-16-47 to 4-27-47
and that I last saw him alive on 4-27-47 1947Immediate cause of death Cardiovascular DURATIONRenal Disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or otherAddress Cumberland Date signed 4-29-47

MARGIN RESERVED FOR BINDING

VS A15 9-4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 3 1947
BUREAU 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of age is shown on 109 4/11/47 MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (93d)

00585
9
Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County... allegany
City or town... Frankfort
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Miners Hospital
How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... md. County... allegany
City or town... Frankfort
(If outside city or town limits, write RURAL and give nearest town)
Street No... 199 E. Main
(If rural, give LOCATION)
2.(a) If veteran, name war...

3. (a) FULL NAME

Emory Messbach

3. (b) Social Security Number

none

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Lula Williams Messbach

7. Birth date of deceased (mo., day, yr.) April 14-1891 6.(c) If alive, give age 52 years

8. AGE: Years 55 Months 56 Days 11 If less than one day 19 hrs. min.

9. Birthplace... Frankfort-alleg-md.
(Town, county, and state)

10. Usual occupation... painter

11. Industry or business

12. Name John Messbach

13. Birthplace Barton, md.

14. Maiden name Susanna Alexander

15. Birthplace md.

16. Informant... Albert Messbach

Address Frankfort, md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof... April 4-1947
(month) (day) (year)

Cemetery or crematorium... Evangelical Lutheran

Location Frankfort, md.

18. Funeral director... J. J. Smith

Address Frankfort md.

19. 4-4 19 47 Mrs. Nancy N. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Apr 2nd 19 47 at 11:00 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946 to Apr 2 19 47

and that I last saw him alive on Apr 2 19 47

Immediate cause of death acute cardiac

decelation

Due to... Chr myocarditis

Due to... several

Other conditions Permeous anemia

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. D. McFarland MD

Address Frankfort md Date signed 4-4-47

RECEIVED

APR 8 1947

BUREAU V 8

DR. MIRKIN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

00586

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HospitalHow long in hospital or institution? 21 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County

ALLEGANYNear CUMBERLAND, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. RT. #3, VALLEY ROAD

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

LA VERNA E. MILLER

3. (b) Social Security Number

None

4. Sex

FEMALE WHITE

5. Color or race

6. (a) Single, married, widowed, or divorced

WIDOWED6. (b) Name of husband or wife LEVI MILLER

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.) APR. 15, 1878

8. AGE:

Years

Months

Days

If less than one day

681120

hrs.

min.

9. Birthplace

W. VA. Huntington,

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name JAMES SHAMBLIN

13. Birthplace

W. Va.14. Maiden name PRICEY BISHOP

15. Birthplace

W. Va.16. Informant Mrs. Raymond BrownAddress RT. 3, Cumberland, Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof April 8, 1947

(month) (day) (year)

Cemetery or crematory Rose Hill CemeteryLocation Cumberland, Md

18. Funeral director

Address

J. P. Franklin, M.D.19. April 6

(Date rec'd by registrar)

19 47J. P. Franklin, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH APR. 5 19 47 at 11:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to Apr 5 19 47and that I last saw him alive on Apr 5 19 47

Immediate cause of death

Pneumonia

DURATION

3 days

Due to

Genital arteriosclerosis?

Due to

Fracture, neck of femur, left3 1/2 mo.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Fracture neck of femur, left

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Home

Means of injury

Fall

Injured at work?

No

23. SIGNATURE

J. P. Franklin, M.D.

M. D. or other

Address

115 S. CentrestDate signed 4-5-47Cumbr Md

MARGIN RESERVED FOR BINDING

I

VS A15 9.4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 15 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

00587

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hospital, Cumberland, Maryland
How long in hospital or institution? 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State West Virginia County Morgan
City or town Slanesville
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION) ✓
2(a) If veteran, name war _____

3. (a) FULL NAME Montgomery, Mr. H. A.
3. (b) Social Security Number None

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Mrs. Estella Montgomery
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) 9/26/80
8. AGE: Years 66 Months 6 Days 8
If less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION
2D. DATE OF DEATH 4/4 1947 at 9:15 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-2 1947 to 4-4 1947
and that I last saw him alive on 4-3 1947
Immediate cause of death autochthon
Due to Diabetes
Due to _____
Other conditions _____
DURATION several years

9. Birthplace Pennsylvania
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business _____
12. Name Joe Montgomery
13. Birthplace Pennsylvania
14. Maiden name Unknown
15. Birthplace Pennsylvania
16. Informant Mrs. Estella Montgomery
Address Slanesville, W. Va.
17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof April 6, 1947
(month) (day) (year)
Cemetery or crematory Noland Cem
Location Near Levels, W. Va.
18. Funeral director W. H. McKee
Address Augusta W. Va.
19. April 6, 1947 J. P. Franklin, M.D. Registrar
(Date rec'd by registrar)

(Include pregnancy within 3 months of death)
Major findings of operations autochthon, jaundice, next fat Date of op. 3-26-47
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
23. SIGNATURE L. Rhiney M.D. M. D. or other
Address 59 Greene St. Date signed 4-4-47

MARGIN RESERVED FOR BINDING

VS A15 9-4-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ARTICLE 10

ARTICLE 10

RECEIVED

APR 16 1947

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town WESTERNPORT
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION) DORCH

2.(a) If veteran, name war

3. (a) FULL NAME

MRS. WILHELMINIA NELAN

3. (b) Social Security Number

None

4. Sex FEMALE	5. Color or race WHITE	6. (a) Single, married, widowed, or divorced WIDOWED
------------------	---------------------------	---

6. (b) Name of husband or wife FRED NELAN

6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) NOV. 12, 1905

8. AGE: Years 41	Months 5	Days 13	If less than one day hrs. min.
---------------------	-------------	------------	-----------------------------------

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation HOUSEWORK

11. Industry or business

12. Name STEPHEN BAGENHARDT

13. Birthplace MARYLAND

14. Maiden name MARY McKINNON

15. Birthplace MARYLAND

16. Informant Ida Bagenhardt

Address Westernport, Md.

Date thereof April 28, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenwood Cem.

Location Brownsville, Pa.

18. Funeral director J. P. Franklin, M.D.

Address Westernport, Md.

19. April 26, 1947 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

APRIL 25, 1947

12:50 A.M.

20. DATE OF DEATH 1947, at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-14-47 to 4-25-47
and that I last saw him alive on 4-24-47

Immediate cause of death

Pathology of
Liver

DURATION

Due to

Due to

Other conditions

found in heart
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. none

Autopsy results See above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.F. Williams

Address Cumberland Date signed 4-26-47

MARGIN RESERVED FOR BINDING

VS A15 9-4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 3 1947

BUREAU

Handwritten notes and signatures, including "Bureau" and "May 3 1947".

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

00589

5

1. PLACE OF DEATH:

County Allegheny
 City or town Rawlings
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 44 yrs.
 Hospital, institution, or street address where death occurred:
U.S. Route 220
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegheny
 City or town Rawlings
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. U.S. Route 220
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Edith S. Dawson Gorman

3. (b) Social Security Number

—

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Richard S. Gorman
 6. (c) If alive, give age 46 years
 7. Birth date of deceased (mo., day, yr.) Oct 5 1903

8. AGE: Years 43 Months 6 Days — If less than one day
 hrs. min.

9. Birthplace Bremerton Ind.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business —

12. Name John Jacob Dawson

13. Birthplace West Va.

14. Maiden name Florence Miller

15. Birthplace West Va.

16. Informant Richard S. Gorman

Address Rawlings, Md.

17. Cremial Date thereof April 8, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bier Cemetery

Location Rawlings, Md.

18. Funeral director Louis Stein Inc.

Address Cumberland, Md.

19. 4/7 47 W. W. Mumst
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1947, at 5:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 12 1942 to April 5 1947 and that I last saw him alive on March 18 1947

Immediate cause of death Cancer of the Cervix Uteri DURATION 7 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. Blum M. D. or other

Address 88 Greene St. Date signed 4-6-47

MARGIN RESERVED FOR BINDING

VS A15

9-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 9 1947

BTCL A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157mm

CERTIFICATE OF DEATH

00590

Reg. Dist. No. 6

1. PLACE OF DEATH:

County AlleganyCity or town McCoole
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town McCoole
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Infant Norrington

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteSingle

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

April 14, 1947

8. AGE:

Years

Months

Days

If less than one day

9

hrs.

min.

9. Birthplace McCoole, Allegany, Md.
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

FATHER

12. Name Charles Andrew Norrington

13. Birthplace

Keyser, W.Va.

MOTHER

14. Maiden name Reva Elizabeth Miers

15. Birthplace

McCoole, Md.16. Informant Charles A. Norrington

Address

P.O. Box 7, Keyser, W.Va.17. Burial
(Burial, cremation, or removal. Which?)Date thereof 4-16-47
(month) (day) (year)

Cemetery or crematory

Queenspoint

Location

Keyser, W.Va.

18. Funeral director

N.H. Rogers

Address

Keyser, W.Va.19. April 20, 1947
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15, 1947 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 14 to April 15 and that I last saw him alive on April 15

Immediate cause of death

Mal formed

DURATION

Due to _____

Due to _____

Other conditions

Right hand + left forearm amputated. Both feet badly deformed
(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

E.G. Courier M.D.

M. D. or other

Address

Keyser W.Va.Date signed 4/15/47

RECEIVED
APR 21 1947
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

00591

1. PLACE OF DEATH:

County: Allegany
 City or town: Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 weeks
 Hospital, institution, or street address where death occurred: Miners Hospital
 How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State: Maryland County: Allegany
 City or town: Mt Savage
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.: _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war: _____

3. (a) FULL NAME

Maude Goodrich Norris

3. (b) Social Security Number

none

4. Sex

Female

5. Color of race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Ernest Norris

7. Birth date of deceased (mo., day, yr.)

July 9, 1890

6. (c) If alive, give age

57 years

8. AGE:

Years

Months

Days

It less than one day

56911

hrs.

min.

9. Birthplace

Mt Savage, Allegany, Md
(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

home

FATHER

12. Name

Leroy Goodrich

MOTHER

13. Birthplace

Maryland

14. Maiden name

Bertha Porter

15. Birthplace

Maryland

16. Informant

Ernest Norris

Address

Mt. Savage, Md.

17. Burial

(Burial, cremation, or regional. Which?)

Date hereof

Apr 23 '47
(month) (day) (year)

Cemetery or crematory

Episcopal Cemetery

Location

Mt. Savage, Md.

18. Funeral director

J. R. Christ

Address

Frostburg, Md.

19. (Date rec'd by registrar)

4-22

19

47Mrs. Nancy N. Roe

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 21 1947 at 7:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 14 1947 to April 21 1947and that I last saw him/her alive on April 20 1947

Immediate cause of death

Carcinoma of liver with metastasis

DURATION

1 yr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation

Carcinoma of liverDate of op. April 7, 47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. E. Lattin M.D.

M. D. or other

Address

Frostburg, Md.Date signed 4/22/47

RECEIVED
APR 24 1947
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DR. TOLSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 181-2

CERTIFICATE OF DEATH

Reg. Dist. No. 00592

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 512 EASTERN AVE.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MR. LAWSON PERDEW

3. (b) Social Security Number

None

4. Sex MALE	5. Color or race WHITE	6. (a) Single, married, widowed, or divorced WIDOWED
----------------	---------------------------	---

6. (b) Name of husband or wife MARY A. (DIEHL) PERDEW

6. (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) OCT. 17 1861

8. AGE:	Years	Months	Days	If less than one day
85	6	10		hrs. min.

9. Birthplace Mansfield, Bedford Co., Pa.
(Town, county, and state)

10. Usual occupation UNABLE TO WORK

11. Industry or business

12. Name ? Perdeu

13. Birthplace Pa

14. Maiden name SUSAN PERDEW

15. Birthplace Pa

16. Informant Eliza H Perdeu

Address 507 Central Ave - Cumberland Md

17. Burial Date thereof April 29 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt Pleasant Methodist Cemetery

Location near Cumberland

18. Funeral director John J. Haley

Address Cumberland Md

19. April 29 1947 J. P. Faulkner, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

APRIL 27, 1947

I; 30 A.M.

20. DATE OF DEATH 19 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-19-1947 to 4-27-1947

and that I last saw him alive on 4-26-1947

Immediate cause of death

arteriosclerosis

DURATION

Due to

Due to

Other conditions Chronic nephritis

Benign hypertrophy prostate
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Howard H. Tolson, M.D.

Address Cumberland Md Date signed 4-29-47

RECEIVED

MAY 3 1947

Handwritten notes and signatures at the bottom of the page, including the name "C. L. ...".

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 468
CERTIFICATE OF DEATH

00593

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

I

9-4

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County... Alligany
City or town... Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 mo
Hospital, institution, or street address where death occurred:
Willowbrook Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Maryland County... Alligany
City or town... Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. Willowbrook Rd.
(If rural, give LOCATION)
2. (a) If veteran, name war...

3. (a) FULL NAME

William Albert Pfeiffer

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Carrie Brasher

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) Jan 6 1875

8. AGE: Years 72 Months 3 Days 20 If less than one day hrs. min.

9. Birthplace Bedford Co. Pa.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name John L. Pfeiffer

13. Birthplace Germany

MOTHER 14. Maiden name Mary E. Wahl

15. Birthplace Germany

16. Informant John Lufan

Address Rural Cumberland

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Apr 22 47
(month) (day) (year)

Cemetery or crematory Willowbrook Cem.

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. April 29 19 47 Joseph P. Dandridge
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 19 47 at 7:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 19 46 to April 26 19 47
and that I last saw him alive on April 26 19 47

Immediate cause of death Cholera DURATION 2 wks.

Due to Carcinoma of liver 6 wks.

Due to cerebrovascular hemorrhage 3 wks.

Other conditions Hypertensive and arterio-sclerotic heart disease 10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. Weissman M.D. M. D. or other
Address 122 Bedford St Date signed 4/28/47
Cumberland, Md.

RECEIVED

MAY 3 1947

BUREAU 18

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00594

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

856 Maryland Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 856 Maryland Ave
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Philip Jacob Piper

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male white married

6. (b) Name of husband or wife 6. (c) If alive, give age

Ludie Wilkison 56 years

7. Birth date of deceased (mo., day, yr.)

Oct. 11, 1870

8. AGE: Years Months Days If less than one day

76 6 4 hrs. min.

9. Birthplace (Town, county, and state)

Brunswick, King George, Md.

10. Usual occupation

Farmer

11. Industry or business

General Farming

12. Name

William Piper

13. Birthplace

Brunswick, Md

14. Maiden name

Mary Martha Groves

15. Birthplace

Frederick Co., Md.

16. Informant

Hesper Harmon

Address 209 Md. Ave - Cumberland Md

17. (Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)

Burial Apr 17, 1947

Cemetery or crematorium

Mt. Olivet Cemetery

Location

Near Cumberland, Md.

18. Funeral director

John J. Haker

Address

Cumberland Md

19. (Date rec'd by registrar)

April 17, 1947

Registrar

J. P. Franklin, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 15 1947 at 3:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 1947 to Apr. 18 1947

and that I last saw him alive on Mar. 10, 1947

Immediate cause of death

Generalized Arteriosclerosis

DURATION 6 weeks

Due to

5 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

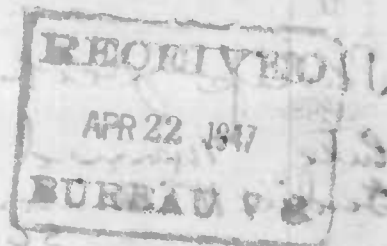
Date signed

4/17/47

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00595

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany
City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred:
Frederick Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County Allegany
City or town Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2nd
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Robert Rankin

3. (b) Social Security Number

214-01-084

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Jan. 14 - 1910

8. AGE: Years 37 Months 3 Days 13 If less than one day _____ hrs. _____ min.

9. Birthplace Allegany Co. Md.
(Town, county and state)

10. Usual occupation Teacher

11. Industry or business Allegany Bridge

12. Name James Rankin

13. Birthplace Frederick

14. Maiden name Estelle Shoenke

15. Birthplace Frederick

16. Informant Mr. James Filkins

Address Frederick P.O. 2 Frederick

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 4-29-1947
(month) (day) (year)

Cemetery or crematory Deer's Cemetery

Location Frederick

18. Funeral director James Filkins

Address Frederick

19. 4-29 1947 Mr. James N. Roe
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1947 at 3:58 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 25 1947 to April 27 1947 and that I last saw him alive on April 26 1947

Immediate cause of death Diabetic Coma DURATION 24 hrs

Due to Diabetes

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hilda Juelhaues M. D. or other
Address Frederick Date signed 4/28/47

MARGIN RESERVED FOR BINDING

VS-A15 9-47-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MAY 2 1947

BUREAU OF

Within 48 hours

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

00596

CERTIFICATE OF DEATH

Reg. Dist. No. 4

VS A15 9-4-41
MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
17 Elder Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 17 Elder Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME ALVEY S. RECKLEY
3. (b) Social Security Number None

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Rosetta E. Brinkman

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9 September 1884

8. AGE: Years 62 Months 7 Days 14
If less than one day hrs. min.

9. Birthplace Allegany County, Maryland.
(Town, county, and state)

10. Usual occupation Minister

11. Industry or business Assembly of God Church

12. Name Charles D. Reckley

13. Birthplace Maryland

14. Maiden name Margaret Raab

15. Birthplace Bermany

16. Informant Rosetta E. Reckley

Address 17 Elder St., Cumberland, Md.

17. Burial Date thereof 26 APR 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Bnnial Park

Location Cumberland, Md.

18. Funeral director Louis Stein, Inc.

Address Cumberland, Maryland.

19. April 25, 47 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH 23 April 1947 19 at 8:15 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 17 to April 23 and that I last saw him alive on April 23

Immediate cause of death Chronic Myocarditis

Due to Chronic Myocarditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert J. Williams M. D. or other

Address West Belts Date signed 4/23/47

*Original Copy
Appended
to
Christy's work*

RECEIVED

APR 29 1947

BUREAU V S

Robert M. ...

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(93a)

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegheny
 City or town Fort Lupton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 43 years
 Hospital, institution, or street address where death occurred:
Consolidation, Fort Lupton, Ind.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County Allegheny
 City or town Consolidation
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Fort Lupton, Ind.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.

3. (a) FULL NAME

George Phibottom

3. (b) Social Security Number

220-10-2724

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Julia Bush6. (c) If alive, give age 54 years

7. Birth date of

deceased (mo., day, yr.)

Mar. 4 - 1886

8. AGE:

Years

Months

Days

It less than one day

61110

hrs.

min.

9. Birthplace

Consolidation, Allegheny, Ind.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Farmer

FATHER

12. Name

Abraham Phibottom

13. Birthplace

Ind.

MOTHER

14. Maiden name

Susan Boyd

15. Birthplace

Ind.

16. Informant

Mrs. Geo. P. Phibottom

Address

Consolidation, Fort Lupton, Ind.

17. Burial

(Burial, cremation, or removal. Which?)

Burial

Date thereof

4-17-1947

Cemetery or crematory

Allegheny Cemetery

Location

Fort Lupton, Ind.

19. Funeral director

James A. Rife

Address

Fort Lupton, Ind.4-16

(Date rec'd by registrar)

47Mrs. Nancy A. Rife

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 19 47 at 6:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2/14 19 47 to 4/14 19 47and that I last saw him alive on 4/12 19 47

Immediate cause of death

Hypertensive heart disease
Cerebral hemorrhage

DURATION

1 year
10 wks

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Hilda J. Rife

M. D. or other

Address Fort Lupton, Ind. Date signed 4/15/47

RECEIVED

APR 18 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(940)

00598

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town 401 N. Mechanic St. Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 60 YearsHospital, institution, or street address where death occurred:
401 North Mechanic St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 636 Fairview Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Joseph Augusta Rice

3. (b) Social Security Number

None4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Mrs Maude E Kauffman Rice6. (c) If alive, give age 58 years7. Birth date of deceased (mo., day, yr.) April 4 18878. AGE: Years 60 Months 0 Days 1 If less than one day
..... hrs. min.9. Birthplace Cumberland, Allegany Co., Maryland
(Town, county, and state)10. Usual occupation Auto Mechanic11. Industry or business Automobiles12. Name Andrew M. Rice13. Birthplace Cumberland, Md.14. Maiden name Sarah Brant15. Birthplace Cumberland, Md.16. Informant Edwin RiceAddress 636 Fairview Ave, Cumberland, Md.17. Burial Date thereof 4/8/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hill Crest CemeteryLocation Cumberland, Md.18. Funeral director William H. KightAddress Cumberland, Md.19. April 8 19 47 J. P. Truckler, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH April 5 19 47 at 8 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19..... to 19.....
and that I last saw him Dead April 5 19 47

Immediate cause of death..... DURATION

Coronary occlusion at

Due to..... once

Due to Arterio sclerosis several

years

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

Deputy Medical Examiner - Allegany23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. or otherAddress Cumberland, Md. Date signed 4/5/47

MARGIN RESERVED FOR BINDING

VS A15 9-4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 15 1947

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00599

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Franklin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Franklin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Elizabeth Riggleman

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Bernard Riggleman
6. (c) If alive, give age 63 years
7. Birth date of deceased (mo., day, yr.) July 20, 1888
8. AGE: Years 58 Months 8 Days 29 hrs. min.

9. Birthplace Sandy Hook, Allegany, Md.
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business Own home

12. Name Henry Norris

13. Birthplace Hagerstown, Maryland

14. Maiden name Sarah Martin

15. Birthplace Connelsville, Penna

16. Informant Bernard Riggleman

Address Franklin, Md

17. Burial Date thereof April 23, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Philos cemetery

Location Westernport, Maryland

18. Funeral director Ellsworth S. Boal

Address Westernport, Maryland

19. April 22 1947 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 19 27 at 8:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 95 19 47 to Apr 19 19 47

and that I last saw him alive on Apr 18 19 47

Immediate cause of death Coronary artery disease

Due to Coronary artery disease

Due to Coronary artery disease

Other conditions Coronary artery disease

(Include pregnancy within 3 months of death)

Major findings of operations Coronary artery disease

Autopsy results Coronary artery disease

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Coronary artery disease Date of April 19 1947

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James H. L. Smith, M.D. M. D. Smith

Address Westernport, Md Date signed 4/21/47

MARGIN RESERVED FOR BINDING

VS A15 9-4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 23 1947

F. B. I. 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00600

1. PLACE OF DEATH:

County Allegany
City or town Cumberland Md. (Amcelle)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Celanese Corp. of Am. (Amcelle)
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany
City or town Morantown Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war.

3. (a) FULL NAME

Samuel Rogane

3. (b) Social Security Number

213-22-3890

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Frances Rogano
6. (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) August 8, 1888

8. AGE: Years 58 Months 8 Days 10 If less than one day
.....hrs.min.

9. Birthplace Italy
(Town, county, and state)

10. Usual occupation Janitor

11. Industry or business Celanese Plant

12. Name unknown

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant Mrs. Rosie Fabbri,

Address Eckhart, Md.

17. Burial Date thereof April 22, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Michael's Centery,

Location Frostburg, Md.

18. Funeral director J. R. Durst,

Address Frostburg, Md.

19. (Date rec'd by registrar) 4/21/47 Registrar M. D. Deming

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 19 47 at 7:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him Dead April 19 19 47

Immediate cause of death Coronary occlusion DURATION about 10 Min.

Due to

Due to

Other conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. M. D. or other

Address Cumberland Md Date signed 4/19/47

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 23 1947

U. S. AIR FORCE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 006014

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 hr.
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 449 N. Centre St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Una W. Schwalm

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Frank H. Schwalm
 6.(c) If alive, give age

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1912
 8. AGE: Years 34 Months 4 Days 24 It less than one day

9. Birthplace Cumberland, Md.
 (Town, county, and state)

10. Usual occupation Garment Factory

11. Industry or business

12. Name Bradford M. Welsh
 13. Birthplace Hyndman, Penna.
 14. Maiden name Belle Valentine
 15. Birthplace Cumberland, Md.

16. Informant Mr. Bradford Welsh
 Address 449 N. Centre St. Cumberland, Md.

17. Burial Date thereof Apr. 12, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Zion Memorial Burial Park
 Location Cumberland, Md.

18. Funeral director Charles L. George
 Address Cumberland, Md.

19. April 11, 47 J. P. Faulkner M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 9, 1947 at 6P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7:00 am to 9:00 am and that I last saw him alive on 9 Apr 1947

Immediate cause of death Acute Dehydration heart

Due to myocarditis

Due to

Other conditions Burbs pneumonia

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. B. Faulkner M. D. or other

Address 112 Bedford St. Date signed 11 Apr 47

MARGIN RESERVED FOR BINDING

VS A15 9-4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 15 1947

F 446

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

DR. R. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00602

1. PLACE OF DEATH:

County... ALLEGANY
 City or town... CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 Days
 Hospital, institution, or street address where death occurred:
 MEMORIAL HOSPITAL
 How long in hospital or institution? 11 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... West Virginia County... Mineral
 City or town... Ridgeley
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 10 Potomac St
 (If rural, give LOCATION)
 2. (a) If veteran, name war...

3. (a) FULL NAME

MRS. SOPHIA SHEPHERD

3. (b) Social Security Number

None

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED

6. (b) Name of husband or wife... CHARLES E. SHEPHERD
 6. (c) If alive, give age... 60 years

7. Birth date of deceased (mo., day, yr.) JANUARY 15, 1889

8. AGE: Years 58 Months 3 Days 5 If less than one day hrs. min.

9. Birthplace... WEST VIRGINIA Great Cacapon
 (Town, county, and state)

10. Usual occupation... HOUSEWIFE

11. Industry or business

12. Name... DANIEL STINBAUGH

13. Birthplace... Great Cacapon, W. Va.

14. Maiden name... CHRISTINA YOUNGBLOOD

15. Birthplace... Great Cacapon, W. Va.

16. Informant... MEMORIAL HOSPITAL

Address... CUMBERLAND, MARYLAND

17. Burial Date thereof 4/23/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Rose Hill Cemetery

Location... Cumberland, Md.

18. Funeral director... William H. Kight

Address... Cumberland, Md.

19. April 23, 1947 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... APRIL 20, 1947, at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on 4/20/47

Immediate cause of death... Myocardial Degeneration

Due to...

Due to...

Other conditions... Spontaneous Pneumothorax (left) Hemothorax

(Include pregnancy within 3 months of death)

Major findings of operations... none

Date of op... none

Autopsy results... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... J. P. Franklin, M.D.

Address... Cumberland Date signed... 4/23/47

RECEIVED

APR 29 1947

BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

00603

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany County Infirmary

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pennsylvania County BedfordCity or town Rural Artemus, Pa.
(If outside city or town limits, write RURAL and give nearest town)Street No. R.D. Artemus
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Edna Roxy Shipley

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Roy C. Shipley

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Jan. 1, 1893

8. AGE:

Years

Months

Days

If less than one day

54323

hrs.

min.

9. Birthplace Chaneyville, Pa.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name Henry C. O'Neal13. Birthplace Penna.

MOTHER

14. Maiden name Emma Leasure15. Birthplace Penna.16. Informant Mr. Roy C. ShipleyAddress R.D. Artemus, Penna.17. Burial Date thereof Apr. 27, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. Zion Cem.Location Near Chaneyville, Pa.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.19. April 26, 1947 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 24, 1947 at 5:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 15, 1947 to Apr. 24, 1947and that I last saw him alive on 1947

Immediate cause of death

Central vascular accident

DURATION

3 daysDue to Arterio-sclerotic renal disease5 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Arthur F. Jones M.D.

M. D. or other

Address 110 S Centre St. Date signed 4-28-47

MARGIN RESERVED FOR BINDING

VS 415 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 29 1947
BUREAU V 8.

(m)

DR. DURRETT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00604

MARGIN RESERVED FOR BINDING

(I)

VS A15 9-4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County
City or town BALTIMORE
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5024 E. Biddle Street
5024 E. BIDDLE ST.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME HARRY SISSELBERGER
3. (b) Social Security Number 215-16-5799

4. Sex MALE
5. Color or race WHITE
6. (a) Single, married, widowed, or divorced Married
SEPARATION
6. (b) Name of husband or wife MARY (MEYERS) SISSELBERGER

7. Birth date of deceased (mo., day, yr.) June 8, 1913
6. (c) If alive, give age 27 years

8. AGE: Years 33 Months 10 Days 5 If less than one day hrs. min.

9. Birthplace MARYLAND, Baltimore
(Town, county, and state)

10. Usual occupation WESTERN ELECTRIC CO.

11. Industry or business Drill Press Operator

12. Name HARRY SISSELBERGER

13. Birthplace MARYLAND

14. Maiden name MARGARET KELLY

15. Birthplace MARYLAND

16. Informant Banklin Funeral Home

Address 9246 Bay St Balto Md

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof April 16, 1947
(month) (day) (year)

Cemetery or crematory Carwood Cem.

Location Baltimore Maryland

18. Funeral director Yunis Thine Inc

Address Cumberland Md

19. April 13, 1947 Registrar J. P. Franklin, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

2D. DATE OF DEATH APRIL 13, 1947 2:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 11 1947 to Apr. 13 1947
and that I last saw alive on Apr. 12 1947

Immediate cause of death Encephalitis

Due to Lagrippa

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE clayd J. J. J.
Address Cumberland Date signed 4/13/47
M. D. or other

DURATION

<u>2 days</u>
<u>3 days</u>

303 Mount Air
Dunsmuir



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00605

Reg. Dist. No. 2

1. PLACE OF DEATH:

County Allegany
 City or town Rural) Flintstone P.O.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Town Creek Rd.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Rural) Flintstone P.O.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5.1/2 miles south of Flintstone Md.
on Town Creek Road.
 2. (a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

Mrs. Goldie Smith
 4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Stillman Snow Smith
 6. (c) If alive, give age 40 years
 7. Birth date of deceased (mo., day, yr.) June 3, 1930
 8. AGE: Years 16 Months 10 Days 14 If less than one day _____ hrs. _____ min.
 9. Birthplace Rockingham Co. Va.
 (Town, county, and state)
 10. Usual occupation House wife
 11. Industry or business at home
 12. Name Perry Smith
 13. Birthplace Va.
 14. Maiden name Martha Susan Hazelrode
 15. Birthplace Va.

16. Informant Perry Smith
 Address Flintstone P.O. Ind.
 17. Burial Date thereof April 20, 47
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Wilson Farm Cem.
 Location Town Creek Rd. Ind.
 18. Funeral director Louis Stein Inc.
 Address Cumturland Ind.
 19. April 20, 47 Nina L. Bender
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH April 17 19 47 at 5.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19 _____ to _____ 19 _____
 and that I last saw her alive Dead April 17 19 47

Immediate cause of death

Intercranial hemorrhage &
Fractured Skull

DURATION

at
once

Due to 12 gauge shot gun load
intering right eye going
through brain & fracturing
skull back of left ear.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide murder Date of 4.17-47
rural- Flintstone P.O. Allegany Md.
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) on Town Creek
bridge near home

Means of injury Shot Injured at work? noDeputy Medical Examiner Allegany

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
 M. D. or other

Address Cumturland Md. Date signed 4/18/47

RECEIVED

APR 22 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00606

DR. WHITWORTH

1. PLACE OF DEATH ALLEGANY

County CUMBERLAND
City or town (If outside city or town limits, write RURAL and give nearest town)How long in above place of death?
Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 128 COLUMBIA ST.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

BABY BOY STEWART

PREMATURE

3. (b) Social Security Number

None

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) APRIL 18, 1947 12:42 A.M. 6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day N.B. 3 hrs. 33 min.

9. Birthplace Cumberland Allegany Co., Md. MEMORIAL HOSPITAL

10. Usual occupation

11. Industry or business GEORGE B. STEWART

12. Name PENNA.

13. Birthplace

14. Maiden name LEAFY SMITH STEWART

15. Birthplace MARYLAND

16. Informant Mr. George Smith

Address 209 Mary St. Cumberland, Md.

17. Burial Date thereof Apr. 19, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Cem.

Location Cumberland, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. April 19, 1947 J. P. Faulkner, Md. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

APRIL 18, 1947 4:15 A.M.

20. DATE OF DEATH 19 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 Apr 1947 to 18 Apr 1947 and that I last saw him alive on 18 Apr 1947

Immediate cause of death

Congenital Abductor

Due to Prematurity

Due to

Other conditions Pleuritic Infection

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Faulkner, Md. M. D. or other

Address 112 Bedford St. Date signed 18 Apr 47

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 22 1947
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00607

Reg. Dist. No.

2

1. PLACE OF DEATH:

County Allegany
 City or town Flintstone
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 months
 Hospital, institution, or street address where death occurred:
Star Route
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County Allegany
 City or town Flintstone
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Star Route
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Mrs Sarah Jane Stewart

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Frank Stewart
 7. Birth date of deceased (mo., day, yr.) May 4, 1858
 6. (c) If alive, give age _____ years

8. AGE: Years 88 Months 11 Days 5 It less than one day _____ hrs. _____ min.

9. Birthplace Flintstone Allegany Co. Ind
 (Town, county and state)

10. Usual occupation Housework

11. Industry or business at Home

12. Name Jacob Kifer

13. Birthplace Ind

14. Maiden name Matilda Smith

15. Birthplace Ind

16. Informant Com Kifer

Address Star Route, Flintstone Ind

17. Burial Date thereof Apr 12, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Glendale Brethren Cemetery

Location Near Flintstone

18. Funeral director John J. Hofer

Address Chamberland Ind

19. April 10 19 47 Nina L. Bender
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 9 19 47 at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 3 19 47 to Apr 9 19 47

and that I last saw him alive on Apr 7 19 47

Immediate cause of death Cerebral hemorrhage DURATION 6 days

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. A. Watson M.D. M. D. or other _____

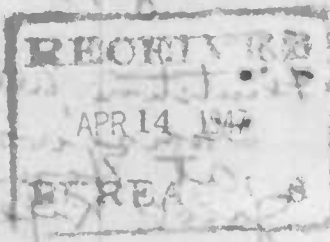
Address Little Orleans Md Date signed 4/10/47

Handwritten notes at top left, including "1000" and "10000".

Handwritten notes at top right, including "10000" and "1000".

Large handwritten notes in the middle section, including "10000" and "1000".

Handwritten number "10000" and "1000".



Handwritten notes at the bottom, including "10000" and "1000".

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of year
of birth is shown on
109 4/24/47

MARYLAND STATE DEPARTMENT OF HEALTH Dr.
2411 N. Charles St., Baltimore (93d)
CERTIFICATE OF DEATH

Reeves

Reg. Dist. No. 00608

1. PLACE OF DEATH:

County Allegany
City or town Westernport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? XXXXXXX 4 days
Hospital, institution, or street address where death occurred:
Reeves Clinic
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State West Virginia County Mineral
City or town Piedmont
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3 Dundee St.
(If rural, give LOCATION) ✓
2. (a) If veteran, name war

3. (a) FULL NAME

RICHARD ALOYSIUS STINE

3. (b) Social Security Number

216-07-2359

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Mary Bridgett (Flynn) Stine 6. (c) If alive, give age 78 years
7. Birth date of deceased (mo., day, yr.) December 1, 1873
8. AGE: Years 74 Months 5 Days 13 If less than one day, give hrs. min.
9. Birthplace Westernport, Allegany, Maryland
(Town, county, and state)
10. Usual occupation Stone mason
11. Industry or business W. Va. Pulp and Paper Co.
12. Name unknown
13. Birthplace unknown
14. Maiden name unknown
15. Birthplace unknown

16. Informant William Stine
Address Piedmont W. Va.
17. Burial Date thereof April 16, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St. Peters Cemetery
Location Westernport, Md.
18. Funeral director Ellsworth S. Boal
Address Westernport, Md.
19. April 16, 1947 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 19 47 at 4:30am
21. I certify that death occurred on the date above stated; that I attended deceased from April 11 19 47 to April 14 19 47
and that I last saw him alive on April 14 19 47

Immediate cause of death

Pneumo. pneumonia
infected

Due to

Chronic Myocarditis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

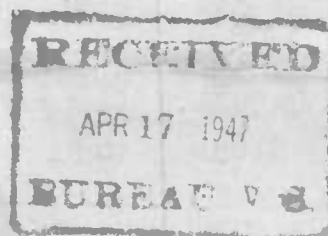
23. SIGNATURE

Norman Reeves M.D.
Address Westernport Md. Date signed 4-16-47

DURATION

3 days
10 "

7 yr.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (923)

00609

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 81 yrs.
 Hospital, institution, or street address where death occurred:
35 Race St.
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 35 Race Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war —

3. (a) FULL NAME

Henry Joseph Straub

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Mary M. Leonard
 6. (c) If alive, give age — years
 7. Birth date of deceased (mo., day, yr.) 20 June 1865
 8. AGE: Years 81 Months 9 Days 23 If less than one day — hrs. — min.

9. Birthplace New Baltimore, Pennsylvania
 (Town, county, and state)
 10. Usual occupation Carpenter
 11. Industry or business own
 FATHER 12. Name Peter Straub
 13. Birthplace Germany
 MOTHER 14. Maiden name Philimma Straub Walker
 15. Birthplace Germany

16. Informant Mary Straub
 Address 35 Race St., Cumberland, Md.
 17. Burial Date thereof April 17, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Mary's Cemetery
 Location Cumberland, Md.
 18. Funeral director Bois Stein, Inc.
 Address Cumberland, Maryland
 19. April 15, 47 J. P. Traubler, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13, 1947 at 9:40 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15, 47 to April 13, 47
 and that I last saw him alive on April 13, 47
 Immediate cause of death Chronic Myocarditis
 DURATION 3 yrs.
 Due to Infirmities of old age
 Due to arteriosclerosis
 Other conditions —
 (Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —
 Autopsy results —
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:
 Accident, suicide, or homicide — Date of —
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) —
 Means of injury — Injured at work? —

23. SIGNATURE MSB Owens MD M. D. or other —
33 Va an Address — Date signed 4/14/47

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 16 1947

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 00610 9

1. PLACE OF DEATH:

County Allegheny
 City or town Freshburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 yrs
 Hospital, institution, or street address where death occurred:
Miner's Hospital
 How long in hospital or institution? 18 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Pa. County Allegheny
 City or town Freshburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 207 Center St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Ida Jane Thomas

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife Clayton Thomas7. Birth date of deceased (mo., day, yr.) Aug. 4 - 1876

8. AGE: Years 70 Months 8 Days 3 If less than one day
 hrs. min.

9. Birthplace Freshburg, Allegheny, Pa.
 (Town, county, and state)

10. Usual occupation Operator

11. Industry or business

12. Name John B. Sharps13. Birthplace Wales14. Maiden name Katherine Porter15. Birthplace Pa.16. Informant Loane ThomasAddress 207 Center St. Freshburg17. Burial (Burial, cremation, or removal, When?) Buried Date thereof 4-10-1947

(month) (day) (year)

Cemetery or crematory Allegheny CemeteryLocation Freshburg, Pa.19. Funeral director Joseph CraperAddress Freshburg, Pa.4-9 1947 Mr. Nancy N. Roe

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1947 12:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 6 1947 to April 7 1947
 and that I last saw him alive on April 7 1947

Immediate cause of death Diabetic acidosis DURATION 21 hrs.

Due to Diabetes Mellitus

Due to

Other conditions Generalized arteriosclerosis
Paraplegia (csp.)
 (Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank T. Harriet MD M. D. or otherAddress 59 East Main St. Date signed 4/8/47Freshburg, Pa.

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APR 12 1947
BUREAU V &

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County... Allegany
 City or town... Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Miners' Hospital
 How long in hospital or institution? 9 weeks 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)
 State... Maryland County... Allegany
 City or town... Eckhart
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Larina Turk

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Anthony Turk

7. Birth date of deceased (mo., day, yr.) February 5, 1900 6. (c) If alive, give age 57 years

8. AGE: Years 47 Months 2 Days 24 If less than one day

8. AGE:

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MEDICAL CERTIFICATION

20. DATE OF DEATH... April 29 19 47 at 3:50 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 19 47 to April 29 19 47

and that I last saw him/her alive on April 29 19 47

Immediate cause of death... Cardiac Embolism DURATION 10 min.

Due to... Amputation left leg 39 days

Due to... Embolism left femoral artery 46 days

Other conditions... Thyroidectomy; parathyroidism; embolism 64 days

(Include pregnancy within 3 months of death) embolism

Major findings of operations... Date of op.

Autopsy results... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... W. E. Gattens, M.D. N. D. or other

Address... Frostburg Md. Date signed 5/1/47

19. 5-2 19 47 Mrs. Gladys N. Roe Registrar

(Date rec'd by registrar)

MARGIN RESERVED FOR BINDING

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9-45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MAY 5 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 921

CERTIFICATE OF DEATH

Reg. Dist. No. 00612

1. PLACE OF DEATH:

County Allegany
 City or town Rural) Little Orleans Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Little Orleans, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Rural) Little Orleans
 (If outside city or town limits, write RURAL and give nearest town)Street No. _____
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Charles Denton Twigg

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widower6. (b) Name of husband or wife Lena Henderson Smolwood7. Birth date of deceased (mo., day, yr.) 15 March 18708. AGE: Years 77 Months 1 Days 11 If less than one day _____ hrs. _____ min.9. Birthplace Maryland
 (Town, county, and state)10. Usual occupation Retired Toolman11. Industry or business Western Md. R.R.12. Name Beck Twigg13. Birthplace Maryland14. Maiden name Unknown15. Birthplace Maryland16. Informant Louise HonAddress Cumberland, Md.17. burial Date thereof April 29, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Methodist CemeteryLocation Orleans Md.18. Funeral director Louis Stein, Inc.Address Cumberland, Md.19. April 28, 1947 Mo. P. Scholtz
 (Date rec'd by registrar) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1947 at 6:50 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____, to _____ 19____
 and that I last saw him alive Dead April 26 1947Immediate cause of death Myocarditis
 DURATION several
years

Due to _____

Due to _____

Other conditions Arterio-sclerosis several
years

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

Deputy Medical Examiner - Allegany23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
 M. D. or other _____Address Cumberland Md. Date signed 4/26/47

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MAY 2 1947

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00613

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 2 yrsHospital, institution, or street address where death occurred:
101 Helen St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 101 Helen St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs Sarah Elizabeth Twigg

3. (b) Social Security Number

None4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife Peter J. Twigg7. Birth date of deceased (mo., day, yr.) Oct 6, 1861 6. (c) If alive, give age _____ years8. AGE: Years 85 Months 6 Days 3 It less than one day _____ hrs. _____ min.9. Birthplace Levens (Town, county, and state) W. Va.10. Usual occupation Housework11. Industry or business At Home12. Name Samuel Robertson13. Birthplace Paw Paw W. Va.14. Maiden name Christine Eichlender15. Birthplace Germany16. Informant Mrs. W. M. JordanAddress 21 Boring St. Cumberland17. (Burial, cremation, or removal, Which?) Burial Date thereof Apr 11, 1947 (month) (day) (year)Cemetery or crematory Rock Hill CemeteryLocation Cumberland and J18. Funeral director John J. HoyerAddress Cumberland, Md.19. April 11, 1947 (Date rec'd by registrar) Jos. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH April 9 19 47 at 7:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 17 19 47 to March 28 19 47and that I last saw him alive on March 28 19 47Immediate cause of death Myocarditis, chronic DURATION 1 yr.Due to Arteriosclerosis unknown

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE R. W. Hershaw, Jr. M. D. or other _____Address Cumberland Md Date signed April 9, 1947

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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APR 15 1947

SECRET

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

Dr Paul R. Wilson 10614

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany
 City or town Westernport
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 80 years
 Hospital, institution, or street address where death occurred:
206 Wood Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Westernport
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 206 Wood Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

JOSEPHINE WEIMER

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband or wife John S. Weimer
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) August 2, 1853

8. AGE: Years 93 Months 8 Days 10 If less than one day _____ hrs. _____ min.

9. Birthplace Frostburg, Allegany, Maryland
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name van Sigler

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Mrs. Almedia Brown

Address Cumberland, Md.

17. Burial Philos Cemetery Date thereof April 15, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Philos Cemetery

Location Westernport, Maryland

18. Funeral director Ellsworth S. Boal

Address Westernport, Maryland

19. Date rec'd by registrar April 15, 1947 Registrar W. J. H. Baker, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12, 1947 at 2:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26, 1947 to Apr. 12, 1947
 and that I last saw him alive on Apr. 12, 1947

Immediate cause of death Chronic Myocarditis and Myocardial Degeneration DURATION 1 Year
Not specified as rheumatic

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Paul R. Wilson, M.D. M. D. or other _____

Address Piedmont, W. Va. Date signed Apr. 13, 1947

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APR 16 1947

BUREAU 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

00615

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 75 yrs

Hospital, institution, or street address where death occurred:

504 Baltimore Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 504 Baltimore Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Wm Franklin Wentling

3. (b) Social Security Number

None4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Florence Virginia Davis

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 18558. AGE: Years 91 Months 10 Days 26 If less than 600 day hrs. min.8. Birthplace Balford Valley, Pa.
(Town, county, and state)10. Usual occupation Saloner (Retired)11. Industry or business State Road12. Name Henry Wentling13. Birthplace Baldwin County, Pa.14. Maiden name Elizabeth A. Hoffman15. Birthplace Cumberland, Md.16. Informant Russell WentlingAddress 518 Baltimore - Cumberland17. Serial Date thereof May 2, 1947
(Burial, cremation, or removal. Which?) month (day) (year)Cemetery or crematory Greenmont CemeteryLocation Cumberland, Md18. Funeral director John J. HylerAddress Cumberland, Md19. May 2 19 47 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 19 47 at 1:45 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/30/47 to 4/30/47and that I last saw him alive on 4/30/47Immediate cause of death chronic myocarditis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John R. Rozum, M.D.
M. D. or otherAddress Cumberland, Md Date signed 5/1/47

MARGIN RESERVED FOR BINDING

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VS A15 9.4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 3 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00616

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 years
 Hospital, institution, or street addresses where death occurred:
405 Avirett Ave.
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 405 Avirett Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war —

3. (a) FULL NAME

FRANK J. WILLIAMS

3. (b) Social Security Number

520-53-1109

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Married</u>
6.(b) Name of husband or wife <u>Caroline Greening GROENING</u>		
6.(c) If alive, give age <u>—</u> years		
7. Birth date of deceased (mo., day, yr.) <u>26 September 1885</u>		
8. AGE:	Years <u>61</u>	Months <u>6</u>
	Days <u>28</u>	It less than one day <u>—</u> hrs. <u>—</u> min.
9. Birthplace <u>Frostburg, Allegheny Co., Md.</u> (Town, county and state)		
10. Usual occupation <u>Grocer</u>		
11. Industry or business <u>Owner</u>		
FATHER	12. Name <u>James Williams</u>	
	13. Birthplace <u>Wales</u>	
MOTHER	14. Maiden name <u>Lavish Williams Williams</u>	
	15. Birthplace <u>England</u>	

16. Informant <u>Frank R. Williams</u>		
Address <u>405 Avirett Ave. Cumberland Md.</u>		
17. <u>burial</u>	Date thereof <u>April 26, 1947</u>	
(Burial, cremation, or removal. Which?)	(month) (day) (year)	
Cemetery or crematory <u>Allegheny Cemetery</u>		
Location <u>Frostburg, Maryland</u>		
18. Funeral director <u>Louis Davis Inc.</u>		
Address <u>Cumberland Md.</u>		
19. <u>April 25, 1947</u>	<u>J. P. Franklin, M.D.</u>	
(Date rec'd by registrar)	Registrar	

MEDICAL CERTIFICATION

20. DATE OF DEATH <u>24 April 1947</u>	19 <u>—</u> , at <u>10</u> P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>1 yr. 47</u> to <u>24 yr. 45</u> and that I last saw him <u>in</u> alive on <u>27 Apr. 45</u>	
Immediate cause of death <u>essential Hypertension</u>	DURATION <u>?</u>
<u>Hypertensive heart disease</u>	
<u>Chronic Cor Pulmonale</u>	
Due to <u>—</u>	
Due to <u>—</u>	
Other conditions <u>—</u>	

(Include pregnancy within 3 months of death)

Major findings of operations <u>—</u>		Date of op. <u>—</u>
Autopsy results <u>—</u>		
PHYSICIAN: Please underline the cause to which death should be charged statistically.		
22. VIOLENCE: If death was due to external causes, fill in the following:		
Accident, suicide, or homicide <u>—</u>	Date of <u>—</u>	
Where did injury occur? <u>—</u>	(City or town)	(County) (State)
Injured at home, farm, industry, public place (where?) <u>—</u>		
Manner of injury <u>—</u>	Injured at work? <u>—</u>	
23. SIGNATURE <u>W. Alfred Van Dorn</u>		
M. D. or other <u>—</u>		
Address <u>Cumt. Md.</u>	Date signed <u>25 Apr. 47</u>	

MARGIN RESERVED FOR BINDING

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9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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APR 29 1947
BUREAU V 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(93d)

00617

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 years
 Hospital, institution, or street address where death occurred:
339 Frederick St
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 339 Frederick St
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Eugene Willis

3. (b) Social Security Number

220-07-6976

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Estella Jones Willis6. (c) If alive, give age 56 years7. Birth date of deceased (mo., day, yr.) July 19 1884

8. AGE: Years 62 Months 8 Days 12 If less than one day
 hrs. min.

9. Birthplace Moorefield, Hardy Co., West Virginia
(Town, county, and state)10. Usual occupation Janitor11. Industry or business Baltimore & Ohio Railroad12. Name Louis Willis13. Birthplace Moorefield, W. Va.14. Maiden name Mammie (Unknown)15. Birthplace Moorefield, W. Va.16. Informant Archibald WillisAddress 312 Howard Place Cumberland, Md.17. Burial Date thereof April 4, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Cumberland, Md.18. Funeral director William H. KightAddress Cumberland, Md.19. April 4 47 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 47, at 5-20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 14, 1946 to April 1, 1947and that I last saw him alive on April 1, 1947

Immediate cause of death

Broncho-Pneumonia DURATION 7 days

Due to

Due to

Other conditions myocardial degeneration

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. M. Schindler M. D. or otherAddress 41 Green St. Date signed April 3, 1947

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 8 1947

BUREAU P S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00618

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
 County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 76 yrs.
 Hospital, institution, or street address where death occurred:
201 Fayette St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 201 Fayette St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME Lillian May Smith Willison 3. (b) Social Security Number None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Arch Willison

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 6 1870

8. AGE: Year 76 Months 4 Days 13 If less than one day hrs. min.

9. Birthplace Cumberland Ind.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at home

12. Name Paige J. Smith

13. Birthplace Vermont

14. Maiden name Sarah D. Wags

15. Birthplace Ind.

16. Informant Miss Dorothy Willison

Address Cumberland

17. Burial Date thereof April 22 47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland Ind.

18. Funeral director Louis Stein Inc.

Address Cumberland

19. April 21 47 J. Potankha M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1947 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2:15 Apr. 19 to 2:30 P.M. 1947

and that I last saw him alive on April 19 1947

Immediate cause of death Pneumonia DURATION 30 min

Edema

Due to not determined

Due to

Other conditions Arterio-sclerosis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Charlotte D. Goodner M.D. or other

Address Cumberland Ind. Date signed Apr 21 47

MARGIN RESERVED FOR BINDING

I

9-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

63d

00619

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH:

County..... Allegany
 City or town..... Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 1 Week

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland..... County..... Allegany

City or town..... Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. R. D. #2 Baltimore Pike
(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (a) FULL NAME

Ella Belle Wilson

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female

White

Married

6. (b) Name of husband or wife..... Jesse M. Wilson

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.) May 22, 1879

8. AGE: Years Months Days If less than one day
67 10 26 hrs. min.9. Birthplace..... Centreville, Penna.
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business

FATHER 12. Name Elza W. Nave

13. Birthplace Penna.

MOTHER 14. Maiden name Rena Laney

15. Birthplace Penna.

16. Informant Mr. Jesse M. Wilson

Address R. D. #2 Cumberland, Md.

17. Burial Date thereof Apr. 20, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Burial Park

Location Cumberland, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. April 20, 1947 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18, 1947, at 5 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/12 1947 to 4/18/47 1947
and that I last saw him alive on 4/17/47 1947

Immediate cause of death

Thyroid crisis

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Thyroidectomy Date of op. 4/17/47

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE J. P. Franklin, M.D.

Address..... Date signed 4/18/47

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APR 29 1947

BUREAU OF

Evidence for change of
birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1315

1522

FILE NO. G 11 MAY 5 1947 CERTIFICATE OF DEATH

Reg. Diat. No. 10

1. PLACE OF DEATH:

County Allegany
City or town Slatten
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs.
Hospital, institution, or street address where death occurred
Slatten, W. S. Savage, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Ind. County Allegany
City or town Slatten
(If outside city or town limits, write RURAL and give nearest town)
Street No. W. S. Savage
(If rural, give LOCATION)
2. (a) If veteran, name war.

3. (a) FULL NAME

Laurence W. Winbrenner

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Flera B. Martins
6. (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Apr. 15 - 1872 1871

8. AGE: Years 76 Months 0 Days 7 If less than one day
hrs. min.

9. Birthplace Boston, Mass. Eckhart, Ind.
(Town, county, and state)

10. Usual occupation Retired Repairman

11. Industry or business C & P. R. R. Co.

12. Name James W. Winbrenner

13. Birthplace Allegany County

14. Maiden name Susanna J. Cogdon

15. Birthplace W. S. Savage, Ind.

16. Informant Mr. Laurence Winbrenner

Address Slatten, W. S. Savage, Md.

17. Burial Date thereof 4-26-47
(Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory W. S. Savage, Ind.

Location W. S. Savage, Ind.

18. Funeral director Robert Raper

Address Frederick, Md.

19. April 23, 47 Registrar James W. Winbrenner
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22nd 1947 at 11:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 21st 1947 to April 22nd 1947
and that I last saw him alive on April 22nd 1947

Immediate cause of death Myocarditis, Aortic Sclerosis
regurgitation - DURATION

Due to

Due to

Other conditions Chronic nephritis.

Generalized edema of body.
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William E. Mowley M. D.

Address W. S. Savage, Ind. Date signed 4/23-47

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 28 1947

BUREAU V. A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

00620

6

1. PLACE OF DEATH: Allegany
 County.....McCoole
 City or town.....10 years
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
90 West St.,
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....Md. County.....Allegany
 City or town.....McCoole
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....91 Maryland Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME Lucretia Virginia Wolfe

3. (b) Social Security Number
None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband or wife Wm. H. Wolfe
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) May 7, 1881
 8. AGE: Years 65 Months 11 Days 15 It less than one day
 hrs. min.

9. Birthplace Newmarket, Virginia
 (Town, county, and state)
 10. Usual occupation Housewife at home
 11. Industry or business
 12. Name Jno. Emswiler
 13. Birthplace Do not know
 14. Maiden name Do not know
 15. Birthplace

16. Informant Mrs. Edgar Smoot
 Address Martinsburg, W. Va.
 17. Burial 4/24/1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or place Queens Point
 Location Keyser, W. Va.
 18. Funeral director B. W. Markwood
 Address Keyser, W. Va.
 19. April 24 47 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22, 19 47 at A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ast. 19 46 to April 22, 19 47
 and that I last saw her alive on April 22, 19 47

Immediate cause of death Myocarditis

Due to.....
 Due to.....

Other conditions Chronic nephritis
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Thad J. Hoffman, M.D.
 M. D. or other
 Address Keyser, W. Va. Date signed 4-23-47

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APR 25 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

CERTIFICATE OF DEATH

00621

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs
Hospital, institution, or street address where death occurred Allegany Co. Infirmary
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 424 Cumberland St.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Margaret Winder

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan 5 1862

8. AGE: Years 85 Months 3 Days 28 If less than one day hrs. min.

9. Birthplace Rawlings, Allegany Co. Ind.
(Town, county, and state)

10. Usual occupation house wife

11. Industry or business

12. Name Fred Winder

13. Birthplace Germany

14. Maiden name Katherine Goetz

15. Birthplace Germany

16. Informant Miss Lena Rader

Address Cumberland

17. Burial Date thereof April 30 '47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Peter & Pauls Chm

Location Cumberland

18. Funeral director Louis H. H. Inc.

Address Cumberland

19. April 29 1947 Joseph C. Tomblin
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1947 at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 3 1946 to Apr. 28 1947

and that I last saw h. er alive on Apr. 26 1947

Immediate cause of death

Central Vascular
Accident

Due to Arterio-sclerotic

hypertensive disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur F. Jones M.D.

M. D. or other

Address 110 S. Centre St. Date signed 4-29-47

MARGIN RESERVED FOR BINDING

VS A15 9-4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 3 1947
BUREAU C S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(131-4)

00622

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 58 yrs.

Hospital, institution, or street address where death occurred:

Allegany HospitalHow long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 105 Wills Creek Avenue

(If rural, give LOCATION)

2. (a) If veteran, name war World War I

3. (a) FULL NAME

WILLIAM ZANTOPP

3. (b) Social Security Number

270-03.7614

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single6. (b) Name of husband or wife None

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 18898. AGE: Years 58 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Cumberland, Allegany Co., Md.

(Town, county, and state)

10. Usual occupation Glassworker11. Industry or business Glass Co.12. Name Frank Zantopp13. Birthplace Bermary14. Maiden name Christina Smith15. Birthplace Unknown16. Informant Louis Stein, Inc.Address Cumberland, Md.17. Burial Date thereof April 26, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Peter's & Paul's CemeteryLocation Cumberland, Maryland.18. Funeral director Louis Stein, Inc.Address Cumberland, Maryland.19. April 25, 47 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 APRIL 1947 19____ at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-24-47 to 4-24-47
and that I last saw him alive on 4-24-47Immediate cause of death uremia

DURATION

12 hoursDue to chronic nephritis

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE L. Franklin MD

M. D. or other

Address 58 Green St. Date signed 4-25-47

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 29 1947

BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(93a)

00623

4

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County AlleghenyCity or town Chamberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yrs.

Hospital, institution, or street address where death occurred:

Allegheny HospitalHow long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County AlleghenyCity or town Chamberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 168 1/2 Center St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Freeman Denton Zembower

3. (b) Social Security Number

None4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Flossie Welsh7. Birth date of deceased (mo., day, yr.) Oct 24, 1893 6.(c) If alive, give age 44 years8. AGE: Years 53 Months 5 Days 15 It less than one day9. Birthplace Bedford County, Pa. (Town, county, and state)10. Usual occupation Farmer11. Industry or business General Farming12. Name Pierce Zembower13. Birthplace Bedford Valley, Pa.14. Maiden name Virgie Kissler15. Birthplace Chamberland, Pa.16. Informant Ross ZembowerAddress Long, W.D.17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Apr 12, 1947
(month) (day) (year)Cemetery or crematory Chelcrest CemeteryLocation Chamberland, W.D.18. Funeral director John J. HaferAddress Chamberland, W.D.19. April 12, 1947 J.P. Franklin, M.D. Registrar

(If rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 19 47 at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 19 47 to April 9 19 47and that I last saw him alive on April 8 19 47Immediate cause of death acute Myocarditis

DURATION

Due to asthma

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Bailey Hunter, M.D. M. D. or otherAddress Chamberland, W.D. Date signed 4/14/47

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

Handwritten notes, possibly a date or reference number.

Handwritten notes, possibly a date or reference number.

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APR 15 1947
BUREAU

Handwritten notes and signatures below the stamp.